Agency 40
Insurance Department

Articles

Article 1.—GENERAL

40-1-1. Officers, directors, trustees; financial interest in sale or loan by company; prohibited. (a) Except as permitted by K.S.A. 1984 Supp. 40-2a13 and 40-2b10 respectively, an officer, director, or trustee of an insurance company, association, or society doing business in this state shall not:

(1) receive any money or valuable item for negotiating, soliciting, procuring, recommending, or aiding in the purchase or sale of property by the company, association, or society;

(2) receive a loan from the company, association, or society; or

(3) have a financial interest as principal, co-principal, agent, or beneficiary in a purchase, sale or loan prohibited by subsections (a)(1) and (a)(2).

(b) An appraisal of the property shall be made prior to purchase or sale of real estate to or from an officer, director or trustee of any insurance company, association or society doing business in this state by an insurance company, association or society. A true copy of the appraisal shall be provided to the commissioner upon request.

(c) A company, association, or society doing business in this state shall not make any loan, other than a policy loan, to an officer, director, trustee or other person having authority in the management of its funds.

(d) This regulation shall not apply to loans permitted by K.S.A. 1984 Supp. 40-2a12 and 40-2b09. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-222, 40-225; effective Jan. 1, 1966; amended Jan. 1, 1969; amended May 1, 1979; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986.)

40-1-2. (Authorized by K.S.A. 40-103, 40-209, 40-216, K.S.A. 1978 Supp. 40-214; effective Jan. 1, 1966; revoked May 1, 1979.)

40-1-3. Foreign insurance companies; deposit requirements. Each insurance company organized under the laws of a country other than the United States shall be treated as a United States domestic company of the state in which the principal office of the company in this country is located. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-209, 40-210; effective Jan. 1, 1966; amended May 1, 1986.)

40-1-4. (Authorized by K.S.A. 40-103, 40-

201, 40-214; effective Jan. 1, 1966; revoked Jan. 1, 1968.)

40-1-5. Insurance companies; changes in charter, bylaws, officers, management; reports to commissioner. The following information shall be filed with the commissioner within 30 days after the changes or actions become effective or are otherwise finalized:

(a) Each change in the charter of an insurance company authorized to transact business in this state;

(b) Each change in the bylaws of insurance companies organized under the laws of this state;

(c) Each change in officers and directors of insurance companies organized under the laws of this state as listed on page one of the annual statement. A biographical sketch of each officer or director shall be filed unless previously filed;

(d) Each entry into or change in management contracts by insurance companies authorized to transact business in this state; and the sale of controlling stock interests. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-209, 40-216, 40-222d, 40-225; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1980; amended May 1, 1981; amended May 1, 1986.)

40-1-6. (Authorized by K.S.A. 40-103, 40-225, 40-404a; effective Jan. 1, 1966; amended Jan. 1, 1970; amended Jan. 1, 1971; revoked May 1, 1979.)

40-1-7. (Authorized by K.S.A. 40-103, 40-235, 40-242, 40-2404, 58-2265; effective Jan. 1, 1966; revoked May 1, 1979.)

40-1-8. (Authorized by K.S.A. 40-103, 40-928(f); implementing K.S.A. 40-216, 40-246a, 40-1113; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986; revoked June 22, 2001.)

40-1-9. Insurance companies; insurance contracts; premiums defined. (a) (1) The following charges made by insurance companies or their representatives, in connection with the issuance or servicing of policies of their insureds, shall be considered "premiums":

(A) Membership fees;

(B) policy fees;

(C) service charges; and

(D) charges made by title insurance companies or their agents for the assumption of the risk created by issuance of the title insurance policy.

(2) "Premiums" shall be subject to each applicable fee and tax, shall be authorized by the applicable rate filings of the company required by chapter 40, Kansas Statutes Annotated, and shall be subject to any other applicable statutes.

(b) This regulation shall not apply to interest permitted or required by K.S.A. 40-282 and 40-283. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-252, 40-283, 40-928, 40-1113; effective Jan. 1, 1966; amended Jan. 1, 1969; amended Jan. 1, 1971; amended May 1, 1979; amended May 1, 1986.)

40-1-10. Insurance companies; premium financing plans; requirements. (a) For the purpose of this regulation, premium financing plans are defined as:

(1) Plans whereby the company offers the insured an installment method of paying premiums for each type of coverage purchased, such as life, casualty, fire, and inland marine or any combination, by combining the total of the premiums and charging an additional finance or service charge for the payment plan; and

(2) plans whereby the company offers the insured an installment method of paying premiums for a line of insurance that is in addition to any installment payment plan recognized by the company's existing rule and rate filings. This includes premium financing plans that are normally handled separately from the insurance contract and handled directly by the insurer or an affiliated insurer.

(b) The following rules are applicable to all insurance companies using a premium financing plan:

(1) Each interest or service charge shall be considered as premium income and the applicable premium taxes shall be paid.

(2) Each interest or service charge shall be reported as separate items on one line in the exhibit of premiums:

(A) contained in exhibit I, page 7, of the annual statement relating to life insurance companies; or

(B) on page 14 of the annual statement relating to other than life insurance companies.

(3) Each fire or casualty insurer shall file with the commissioner each manual of rules and rates, together with each form and modification of any rules, rates and forms used in connection with premium financing plans. Each filing shall indicate the character and extent of the interest or service charges contemplated and shall be accom-

panied by all pertinent information supporting the filing.

(4) Except as provided in K.S.A. 40-411 or K.S.A. 40-420, each form shall provide at least five days written notice of cancellation to an insured before the policy may be cancelled as a result of a premium installment nonpayment. (Authorized by K.S.A. 40-103, 40-2203(G); implementing K.S.A. 40-252, 40-928, 40-1113, 40-2203; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986.)

40-1-11. (Authorized by K.S.A. 40-103, 40-216, 40-2207, 40-2404; effective Jan. 1, 1966; revoked May 1, 1979.)

40-1-12. Insurance companies; unauthorized writing of insurance; premium tax. Each insurance company writing insurance in this state on the life or person of state residents, or on property located within this state, without authorization from the commissioner of insurance shall, after receiving authorization to transact business in this state, be assessed the amount of premium tax specified in K.S.A. 40-252 (B) for the calendar year in which the company receives authorization and for the two preceding years. Companies conducting business by mail or on federal installations within this state shall not be exempt from this requirement. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-214, 40-246a, 40-252; effective Jan. 1, 1966; amended May 1, 1986.)

40-1-13. (Authorized by K.S.A. 40-103; implementing 40-246a, 40-252; effective Jan. 1, 1966; amended Jan. 1, 1973; amended May 1, 1986; revoked June 22, 2001.)

40-1-14. (Authorized by K.S.A. 40-103, 40-208, 40-209, 40-216, 40-926, 40-1111, K.S.A. 1978 Supp. 40-928, 40-1113; effective Jan. 1, 1966; revoked May 1, 1979.)

40-1-15. Insurance companies; approval of forms; company names. (a) A policy form shall not contain the name of an insurance company that is unauthorized to transact business in Kansas.

(b) If the policy contains the name of more than one company authorized to transact business in Kansas, the policy shall clearly provide for the designation, when issued, of the company, or companies, assuming direct liability on the contract. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-214, 40-216, 40-2215(C); effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1981; amended May 1, 1986.)

40-1-16. Insurance companies; approval of forms; advertising. (a) An application form, policy form, plan, certificate of coverage, rider, endorsement, or other form to be attached to a policy, shall not contain advertising which:

(1) Misleads,

(2) does not materially facilitate understanding of the form; or

(3) does not facilitate identification of the insurer. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-216, 40-2404; effective Jan. 1, 1966; amended Jan. 1, 1968; amended May 1, 1979; amended May 1, 1986.)

40-1-17. Insurance companies; policy forms; return of unearned premium; condition precedents prohibited. When an insurance policy provision provides for the return of unearned premium, the provision shall not require the insured to request the return of premium, or that the premium is returned only "upon demand." (Authorized by K.S.A. 40-103, 40-2203(G); implementing K.S.A. 40-216, 40-2203(8), 40-2215; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986.)

40-1-18. (Authorized by K.S.A. 40-103, 40-216, 40-235, 40-2203, 40-2203(G); effective Jan. 1, 1966; revoked May 1, 1979.)

40-1-19. Insurance companies; combination policies; requirements. Each company authorized to transact business in this state shall be prohibited from issuing a policy which combines insurance for which rate filings are required with insurance for which rate filings are not required. This regulation shall not apply to the following:

(a) any policy for which:

(1) the premium for insurance coverage which is not subject to rate control is less than 50% of the total premium; or

(2) the rate for each insurance coverage which is included in the policy is filed with and approved by the commissioner; or

(b) any policy combining life and accident and sickness insurance pursuant to K.S.A. 40-401. (Authorized by K.S.A. 40-103, 40-2204(G); implementing K.S.A. 40-926, 40-927, 40-1111, 40-1112, 40-1113, 40-2203; effective Jan. 1, 1966; amended Jan. 1, 1967; amended May 1, 1979; amended May 1, 1986; amended May 16, 1997.)

40-1-20. Same; subrogation clause prohibited for certain coverages. An insurance company shall not issue contracts of insurance in Kansas containing a "subrogation" clause applicable to coverages providing for reimbursement of medical, surgical, hospital or funeral expenses. (Authorized by K.S.A. 40-103, 60-217(a); implementing K.S.A. 40-216, 40-1110, 40-2201, 40-2203, 40-2204; effective Jan. 1, 1966; amended Jan. 1, 1967; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987.)

40-1-21. (Authorized by K.S.A. 40-103, 40-209, 40-239, K.S.A. 1978 Supp. 40-214, 40-246; effective Jan. 1, 1966; revoked May 1, 1979.)

40-1-22. Insurance policies; change of name or merger of an insurance company; assumption of risk endorsements; requirements. (a) The assuming company shall attach to each policy an "assumption of risk" endorsement that displays the name and address of the assuming company when any outstanding policy of insurance issued to a resident of Kansas is affected by:

(1) a change in the name of the issuing company;

(2) a merger, consolidation or similar transaction involving the issuing company;

(3) a change of domicile in which policy liability is assumed by another company; or

(4) an assumption reinsurance agreement.

(b) The "assumption of risk" endorsement shall be approved by the commissioner of insurance before issuance to residents of the state of Kansas.

(c) An "assumption of risk" endorsement originating from an assumption reinsurance agreement shall not:

(1) require the insured to take affirmative action to reject the substitution of one insurer for another; or

(2) state that failure to reject such substitution or the continued payment of premium will constitute acceptance of the substitution. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-221(a), 40-309, 40-510, 40-1220, 40-1221, 40-1222; effective Jan. 1, 1967; amended May 1, 1979; amended May 1, 1986; amended March 28, 1994.)

40-1-23. (Authorized by K.S.A. 40-103, K.S.A. 1978 Supp. 40-252; effective Jan. 1, 1971; revoked May 1, 1979.)

40-1-24. (Authorized by K.S.A. 40-103, 40-2801, 40-2802, 40-2803, 40-2804, 40-2805, 40-2806, 40-2807, 40-2808, 40-2810, 40-2811, K.S.A. 1978 Supp. 40-2809; effective Jan. 1, 1971; revoked May 1, 1979.)

40-1-25. (Authorized by K.S.A. 40-103, 40-226; effective Jan. 1, 1973; amended May 1, 1979; revoked May 1, 1986.)

40-1-26. (Authorized by K.S.A. 40-103, 40-254; effective Jan. 1, 1973; revoked May 1, 1986.)

40-1-27. (Authorized by K.S.A. 40-103, 40-251, 40-2214; effective Jan. 1, 1973; amended May 1, 1979; revoked May 1, 1986.)

40-1-28. Insurance holding companies; information required; disclaimer of affiliation; termination of registration; acquisition of control. National association of insurance commissioners insurance holding company system model regulation with reporting forms and instructions, June 1986 edition, is hereby adopted by reference, subject to the following exceptions:

(a) Sections 1, 2 and 3 are not adopted;

(b) section 4(b) is completed by inserting "Two"; "Kansas, 420 S.W. 9th Street, Topeka, Kansas"; "Chief Examiner"; and, "30" respectively in the spaces provided;

(c) section 4(a) is amended by substituting "K.S.A. 40-3304 and 40-3305" for "Sections 3, 4 and 5 of this Act" appearing in the first sentence;

(d) section 6(b)(3) is completed by inserting "30" in the space provided;

(e) section 8 is hereby amended by the addition of the following: "The Act means the statutes relating to insurance holding companies contained in Article 33, Chapter 40 Kansas Statutes Annotated";

(f) section 9 is not adopted;

(g) section 10 is amended by substituting "K.S.A. 40-3304" for "Section 3 of the Act";

(h) section 12(a) is amended by substituting "K.S.A. 40-3304(a)" for "Section 3(a)(1) of the Act";

(i) section 12(b) is amended by substituting "K.S.A. 40-3304(a)" for "Section 3(a)(1)";

(j) section 13 is amended by substituting "K.S.A. 40-3305" for "Section 4 of the Act";

(k) section 14 is amended by substituting "K.S.A. 40-3305" for "Section 4 of the Act";

(l) section 15 is not adopted;

(m) section 16(a) is amended by substituting "K.S.A. 40-3305" for "Section 4 of the Act" appearing in the first sentence;

(n) section 16(d) is amended by substituting "K.S.A. 40-3305(f) or K.S.A. 40-3305(g)" for "Section 4(h) or 4(i) of the Act";

(o) section 19(b) is not adopted;

(p) section 20 is amended by substituting "K.S.A. 40-3305(b)" for "Section 5(d) of the Act";

(q) section 21 is added as follows: "Section 21. Acquisition of control—statement filing. (1) A person required to file a statement pursuant to K.S.A. 40-3304 shall, prior to committing any act towards the acquisition of control of a domestic insurer, file a letter with the commissioner of insurance indicating:

(A) the person's interest in the possible acquisition of control;

(B) the name of the domestic insurer to be acquired;

(C) that the person is aware of and will comply with the applicable provisions of the Kansas insurance holding companies act; and

(D) that all negotiations or agreements to acquire control of the domestic insurer will be conditioned upon the approval of the commissioner of insurance.

(2) A person required to file a statement pursuant to K.S.A. 40-3304 shall furnish the required information on form A, hereby made a part of this regulation."

(r) item 12(b) and (c) of form A is amended to read as follows: "(b) The financial statements shall include the annual financial statements of the persons identified in item 2(c) for the preceding five fiscal years or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence, and similar information covering the period from the end of such person's last fiscal year, to a date not earlier than 90 days prior to the filing of the Form A. Such statements may be prepared on either an individual basis, or on a consolidated basis if such consolidated statements are prepared in the usual course of business.

Unless otherwise permitted by the commissioner, the annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, if they are based on the annual statement of such person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer, and if distributed, of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by form A or K.S.A. 40-3304."

(s) item 13 is amended by substituting "K.S.A. 40-3304" for "Section 3 of the Act";

(t) the second sentence of item 2(c) of form A is not adopted;

(u) the second sentence of item 2 of form B is not adopted;

(v) item 5 of form B is amended by substituting "K.S.A. 40-3305" for "Section 4 of the Act";

(w) item 10 of form B is amended by substituting "K.S.A. 40-3305" for "Section 4 of the Act"; and

(x) the signature section of form C is amended by substituting "K.S.A. 40-3305" for "Section 4 of the Act." (Authorized by K.S.A. 40-103, 40-3309; implementing K.S.A. 40-3304(a) and (b), 40-3305 and 40-3306 as amended by 1991 SB 67, Secs. 4 & 5; effective May 1, 1976; amended May 1, 1979; amended May 1, 1986; amended May 1, 1988; amended May 15, 1989; amended, T-40-9-26-91, Sept. 26, 1991; amended Dec. 16, 1991.)

40-1-29. (Authorized by K.S.A. 40-103, 40-3309; implementing K.S.A. 40-3306(c); effective May 1, 1976; amended May 1, 1986; revoked May 1, 1988.)

40-1-30. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-222, 40-225; effective Feb. 15, 1977; amended May 1, 1986; revoked May 25, 2001.)

40-1-31. Insurance policies; prohibiting certain discriminations. An insurance policy, plan or binder, or a rider or endorsement thereto,

shall not be delivered or issued for delivery in this state if the amount of benefits payable, or a term, condition, or type of coverage is or may be restricted, modified, excluded, or reduced on the basis of the sex or marital status of the insured or prospective insured. This requirement shall not apply when the amount of benefits, terms, conditions, or type of coverage vary as a result of the application of rate differentials permitted under chapter 40, Kansas statutes annotated, or as a result of negotiations between the insurer and insured. Nothing in this regulation shall prohibit an insurer from taking marital status into account for the purpose of defining persons eligible for dependents benefits. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-2404(7); effective Feb. 15, 1977; amended May 1, 1986.)

40-1-32. Insurance companies; riders or endorsements; change in coverage or benefits; consent of policyholder. Consent of the policyholder is required if an endorsement or rider attached to an insurance contract or policy subsequent to the issuance date of such contract or policy reduces or eliminates coverage or benefits of the contract or policy. (Authorized by K.S.A. 40-103, 40-2404(a); implementing K.S.A 40-928, 40-1113, 40-2404; effective May 1, 1979; amended May 1, 1986; amended May 1, 1987.)

40-1-33. Suspension of form filing requirements. The filing requirements of K.S.A. 40-216 shall be suspended when insurance policies, endorsements, riders, and other forms cannot be filed before use because:

(a) A change in company officers makes obsolete the signatures appearing on existing forms. If the validity of contracts issued subsequent to such a change in officers would be affected, the filing requirements shall not be suspended; or

(b) an existing supply of forms is depleted and the replacement forms bear a different printing date or edition identity.

This suspension shall not apply to any other changes. (Authorized by K.S.A. 40-103, 40-216; implementing K.S.A. 40-216; effective May 1, 1981; amended May 1, 1986.)

40-1-34. Unfair claims settlement practices. The national association of insurance commissioners' "unfair claims settlement practices model regulation," January 1981 edition, is hereby adopted by reference, subject to the following exceptions:

(a) Section 1 is not adopted.

(b) The first sentence of section 2 is not adopted.

(c) In section 2, the phrase "Section 4(9) of the Act" is replaced with the phrase "K.S.A. 40-2404, and amendments thereto."

(d) In section 3, the phrase "Section 2 of the Unfair Trade Practice Act" is replaced with the phrase "K.S.A. 40-2404, and amendments thereto."

(e) Section 8(d) is not adopted.

(f) Section 8 is amended by the addition of the following subsection: "(e) An insurer shall not attempt to settle a loss with a first party claimant on the basis of a cash settlement which is less than the amount the insurer would pay if repairs were made, other than in total loss situations, unless such amount is agreed to by the insured."

(g) Section 8 is further amended by the addition of the following subsection: "(f) If a claim is denied for reasons other than those described in section 8(a) and is made by any other means than writing, an appropriate notation shall be made in the claim file of the insurer."

(h) Section 8 is further amended by the addition of the following subsection: "(g) Insurers shall not fail to settle first party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions."

(i) Section 8 is further amended by the addition of the following subsection: "(h) Insurers shall not continue negotiations for settlement of a claim directly with a claimant who is neither an attorney nor represented by an attorney when the claimant's rights may be affected by a statute of limitations or a policy or a contract time limit, without giving the claimant written notice that the time limit may be expiring and may affect the claimant's rights. Such notice shall be given to first party claimants thirty days and to third party claimants sixty days before the date on which such time limit may expire."

(j) Section 8 is further amended by the addition of the following subsection: "(i) No insurer shall make statements which indicate that the rights of a third party claimant may be impaired if a form or release is not completed within a given period of time unless the statement is given for the purpose of notifying the third party claimant of the provision of a statute of limitations."

(k) Section 9(a) is amended by deleting the phrase "first party."

(l) In section 9(a), subsection (1) is amended by replacing the word "insured" with the word "claimant."

(m) In section 9(a), subsection (2) is not adopted by reference and is replaced with the following language: "The insurer may elect to pay a cash settlement, based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost shall be determined by any source or method for determining statistically valid fair market value that meets both of the following criteria:"

"(A) The source or method's database, including nationally recognized automobile evaluation publications, shall provide values for at least eighty-five percent (85%) of all makes and models of private passenger vehicles for the last fifteen (15) model years taking into account the values for all major options for such vehicles; and"

"(B) the source, method, or publication shall provide fair market values for a comparable automobile based on current data available for the local market area as defined in subsection (j)(2)."

(n) In section 9(a), subsection (3) is not adopted by reference and is replaced with the following language: "When an automobile total loss is settled on a basis which deviates from the methods and criteria described in subsections (a)(1) and (a)(2)(A) and (B) of this section, the deviation must be supported by documentation giving the particulars of the automobile condition and the basis for the deviation. Any deviations from such cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the claimant."

(o) Section 9 is amended by the addition of the following subsection: "(h) Insurers shall include consideration of applicable taxes, license fees, and other fees incident to transfer of evidence of ownership in third party automobile total losses and shall have sufficient documentation relative to how the settlement was obtained in the claim file. A measure of damages shall be applied which will compensate third party claimants for the reasonable loss sustained as the proximate result of the insured's negligence."

(p) Section 9 is further amended by the addition of the following subsection: "(i) A claimant has the right of recourse if the claimanat notifies the insurer, within thirty (30) days after the receipt of the claim draft, that claimant is unable to purchase a comparable automobile for the amount of the claim draft. Upon receipt of this notice, the insurer shall reopen its claim file within five (5) business days, and one of the following actions shall apply:"

"(1) the insurer shall either pay the claimant the difference between the market value as determined by the insurer and the cost of the comparable vehicle of like kind and quality which the claimant has located, or negotiate and effect the purchase of this vehicle for the claimant; or"

"(2) the insurer may elect to offer a replacement in accordance with provisions of subsection 9(a)(1)."

(q) Section 9 is further amended by the addition of the following subsection: "(j) As used in this regulation, the following terms shall have the following meanings:"

"(1) comparable automobile means a vehicle of the same make, model, year, style and condition, including all major options of the claimant vehicle;"

"(2) local market area means the fifty (50) mile area surrounding the place where the claimant vehicle was principally garaged." (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 2001 Supp. 40-2404; effective May 1, 1981; amended May 1, 1986; amended July 10, 1989; amended Jan. 10, 2003.)

40-1-35. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-2404; effective May 1, 1981; amended May 1, 1986; revoked Dec. 28, 1998.)

40-1-36. Life and health insurance applications; underwriting; acquired immunodeficiency syndrome (AIDS); defined. (a) As used in this regulation, these terms shall have the following meanings:

(1) "Acquired immunodeficiency syndrome (AIDS)" means one or more opportunistic diseases which are at least moderately indicative of underlying cellular immunodeficiency, along with the absence of all known underlying causes of cellular immunodeficiency and all other causes of reduced resistance reported to be associated with at least one of those opportunistic diseases.

(2) "AIDS related complex (ARC)" means a syndrome in which the individual displays many

of the same symptoms of AIDS, including the presence of the HIV antibody.

(3) "Adverse underwriting decisions" mean the actions described in K.S.A. 40-2,111(a).

(4) "Applicant" means the individual proposed for coverage.

(b) All individual and group applications for insurance that require health information or questions shall comply with the following standards:

(1) Whenever an applicant is requested to take an HIV antibody test in connection with an application for insurance, the insurer shall:

(A) Obtain written informed consent from the applicant;

(B) reveal the use of the test to the applicant;

(C) provide the applicant printed material prior to testing containing factual information describing AIDS, its causes, symptoms, how it is and can be spread, the tests used to detect the HIV antibody and what a person should do whose test results are positive; or, arrange for the applicant to receive relevant counseling from a qualified practitioner who has had extensive training and experience in addressing the fears, questions and concerns of persons tested for the HIV antibody;

(D) administer an initial test which meets the test protocol established by the food and drug administration of the federal department of health and human services;

(E) administer a second test, the immunoelectroprecipitate using disrupted whole virus antigen test (western blot), to substantiate an initial positive test result; and

(F) disclose the results of the testing in accordance with K.S.A. 40-2,112(b)(2) and (3).

(2) Insurers may ask diagnostic questions on applications for insurance.

(3) Application questions shall be formed in a manner designed to elicit specific medical information and not lifestyle, sexual orientation or other inferential information.

(4) Questions which are vague, subjective, unfairly discriminatory, or so technical as to inhibit a clear understanding by the applicant are prohibited.

(c) All underwriting shall be based on individual review of specific health information furnished on the application, any reports provided as a result of medical examinations performed at the company's request, medical record information obtained from the applicant's health care providers or any combination of the foregoing. Adverse underwriting decisions shall not be based on less than conclusive responses to application questions.

(d) Adverse underwriting decisions shall be based on sound actuarial principles pursuant to K.S.A. 40-2,109. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-2,109, 40-2404(7) as amended by L. 1987, Ch. 171, Sec. 1; effective, T-88-35, Sept. 17, 1987; amended May 1, 1988.)

40-1-37. Audited financial reports; filing requirements. The Kansas insurance department's "policy and procedure requiring annual audited financial reports," dated October 20, 2005, is hereby adopted by reference. (Authorized by K.S.A. 40-103 and K.S.A. 40-225; implementing K.S.A. 40-225; effective July 10, 1989; amended Jan. 4, 1993; amended Sept. 14, 2001; amended Sept. 21, 2007.)

40-1-38. Insurance companies; hazardous financial condition; standards; corrective actions. Sections 3 and 4 of the national association of insurance commissioner's "model regulation to define standards and commissioner's authority for companies deemed to be in hazardous financial condition," June 1985 edition, are hereby adopted by reference. (Authorized by K.S.A. 40-103; implementing K.S.A. 1990 Supp. 40-222b and K.S.A. 40-222d; effective, T-40-9-26-91, Sept. 26, 1991; effective Jan. 6, 1992.)

40-1-39. Insurance; endorsements and riders; change in coverage; consent of policyholder. (a) No company, or company representative shall be permitted to add coverage to new, renewal, or existing policies if the insured or policyowner has not consented to additional coverage.

(b) This regulation does not apply if a coverage addition is:

(1) Provided without any additional premium charge;

(2) mandated by law; or

(3) required by filings approved for the company's use. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-443, 40-444, 40-941, 40-2403, K.S.A. 1992 Supp. 40-928, 40-1113, 40-2215; effective Nov. 29, 1993.)

40-1-41. Insurance companies; managing general agents; management agreements or contracts; definitions; requirements; prohibitions. (a) This regulation shall:

(1) Apply to managing general agents as defined by K.S.A. 1992 Supp. 40-2,130; and

(2) not apply to administrators holding a certificate of registration pursuant to K.S.A. 40-3810, as amended.

(b) Definitions.

(1) "Payments" means amount paid to any person, organization or corporation pursuant to a management contract or agreement in excess of reimbursement of actual expenses.

(2) "Reimbursement" means amounts paid to any person, organization or corporation pursuant to a management contract or agreement to cover the costs or actual expenses incurred in procuring or otherwise managing the business of any insurer.

(c) Any management agreement or contract which provides for payments, other than reimbursement for actual expenses, in excess of the guidelines contained in subsections (c) through (g) of this regulation shall be deemed by the commissioner of insurance to be in violation of K.S.A. 1992 Supp. 40-2,132, as operating to the financial detriment of the insurer in such a manner as to endanger the financial stability of the insurer or otherwise be hazardous to policyholders and creditors of the insurer.

(d) No payment shall exceed reimbursement plus a percentage of the reimbursement equal to the percentage profit experienced by the company over the previous five years.

(e) Profit shall be calculated as follows:

(1) For property/casualty insurers—net income divided by premium earned;

(2) for life/health/accident insurers—net income divided by premium and annuity consideration, annuity and other fund deposits, and consideration for supplementary contracts; and

(3) for health maintenance organizations—net income divided by premium.

(f) For insurers with fewer than five years experience, the payments shall not exceed 15 percent of the actual expenses reimbursed.

(g) In no case shall the payments exceed 20 percent of the actual expenses reimbursed.

(h) No management agreement or contract shall allow for reimbursement based on a percentage of premium. (Authorized by K.S.A. 40-103, K.S.A. 1992 Supp. 40-2,136; implementing K.S.A. 1992 Supp. 40-2,136; effective Nov. 29, 1993.)

40-1-42. Electronic filing and filing financial statements. (a) "Insurer," as used in this regulation, shall mean the following entities that are operating under the designated articles of chapter 40 of the Kansas statutes annotated and amendments thereto:

(1) An insurance company operating under article 3, 4, 5, 6, 8, 9, 10, 11, 12, 12a, 13, 15, or 35;

(2) a fraternal benefit society operating under article 7;

(3) a reciprocal operating under article 16;

(4) a nonprofit dental service corporation operating under article 19a;

(5) a nonprofit medical and hospital service corporation operating under article 19c; and

(6) a health maintenance organization operating under article 32.

(b) Each insurer that does business in this state and files a statement of its condition dated December 31 of the preceding year on a form prescribed by the national association of insurance commissioners shall, pursuant to K.S.A. 40-225 and amendments thereto, submit the statement of its condition by electronically readable means to the national association of insurance commissioners on January 1 of each year or within 60 days thereafter. The statement of the insurer's condition shall be prepared in accordance with the instructions and the accounting practices and procedures prescribed and adopted periodically by the national association of insurance commissioners and any additions or amendments that the commissioner of insurance requires.

(c) Each insurer organized under the laws of this state and either licensed or operating in any other state shall file quarterly statements of its condition dated the preceding March 31, June 30, and September 30 on a form prescribed by the national association of insurance commissioners.

(1) Each quarterly statement shall be prepared in accordance with the instructions and the accounting practices and procedures prescribed and adopted periodically by the national association of insurance commissioners and any additions or amendments that the commissioner of insurance requires.

(2) Each insurer shall submit the quarterly statement of its condition by electronically readable means to the national association of insurance commissioners within 45 days after the end of that reporting period. (Authorized by K.S.A. 40-103 and 40-225; implementing K.S.A. 40-225; effective Jan. 24, 1997; amended May 25, 2001; amended Dec. 2, 2005.)

40-1-43. Reinsurance trust instruments; letters of credit. (a) Sections 10 and 11 of the national association of insurance commissioners' "credit for reinsurance model regulation," January 1997 edition, with amended pages 5 through 22 dated July 2001, are adopted by reference, subject to the following exceptions:

(1) In section 10(B)(1), delete "Section [insert citation to state law equivalent to Section 4B of the Credit for Reinsurance Model Law]," and replace it with "K.S.A. 40-221a and amendments thereto."

(2) In section 10(B)(11)(c), delete "Section [insert citation to state law equivalent of Section 4B of the Credit for Reinsurance Model Law]," and replace it with "K.S.A. 40-221a and amendments thereto."

(3) Section 10(D)(4) is not adopted by reference.

(4) In section 11(A), delete "Section [insert citation to state law equivalent of Section 4A of the Credit for Reinsurance Model Law]," and replace it with "K.S.A. 40-221a and amendments thereto."

(5) In section 11(G), delete "Section [insert citation to state law equivalent to 4A of the Credit for Reinsurance Model Law]," and replace it with "K.S.A. 40-221a and amendments thereto."

(b) Each trust that is used by an insurer, organized under the laws of this state, to demonstrate compliance with K.S.A. 40-221a(b)(1) and (3), and amendments thereto, shall be established in a form approved by the commissioner. The trust instrument shall include all of the following provisions:

(1) Entry of the final order of any court of competent jurisdiction in the United States will make contested claims valid and enforceable.

(2) Legal title to the assets of the trust will be vested in the trustee for the benefit of the grantor's United States ceding insurers, their assigns, and successors in interest.

(3) The commissioner will have the power to examine the trust.

(4) The trust will remain in effect for as long as the assuming group or insurer has outstanding obligations under reinsurance agreements subject to the trust.

(5) On or before February 28 of each year, a written report prepared by the trustees will be sent to the commissioner of insurance containing the following:

(A) The balance in the trust;

(B) a listing of the trust's investments at the end of the preceding year; and

(C) a certification of the termination date of the trust, or a certification that the trust will not expire before the following December 31.

(c) Each amendment to the trust shall be reviewed and approved by the commissioner before that amendment becomes effective. (Authorized by K.S.A. 40-221a and K.S.A. 40-103; implementing K.S.A. 40-221a; effective Jan. 24, 1997; amended May 25, 2001; amended, T-40-12-11-01, Dec. 11, 2001; amended April 19, 2002.)

40-1-44. Actuarial opinions and memorandums. The Kansas insurance department's "policy and procedure relating to actuarial opinions and memorandums," dated July 9, 2004, is hereby adopted by reference. (Authorized by and implementing K.S.A. 40-409, as amended by L. 2004, ch. 128, sec. 1; effective Jan. 24, 1997; amended June 3, 2005.)

40-1-45. Release of data from the insurance database. (a) Although the data collected by and furnished to the commissioner of insurance pursuant to K.S.A. 40-2251, and amendments thereto, is not an open record pursuant to K.S.A. 1997 Supp. 45-221(16), and amendments thereto, compilations of this data may be released, subject to the following limitations.

(1) These reports shall include comparative information on averages of data collected. Compilations of data shall not contain patient-identifying information or trade secrets.

(2) The raw data shall be released by the commissioner of insurance only to each data provider that has submitted that particular data to the database and that requests to see and review its dataset for purposes of verifying information in the database pertaining to that data provider. These datasets shall not be made available to the public.

(3) External data used for normative values that are not within the public domain shall not be released.

(b) Any person, organization, governmental agency, or other entity may request the preparation of compilations of data collected by and furnished to the commissioner of insurance, in accordance with the following procedure and limitations.

(1) All requests for compilations of data shall be made in writing to the commissioner of insurance. The written request shall contain the name, address, and telephone number of the requester,

and a description of the legitimate purpose of the requested compilation. A "legitimate purpose" is defined as a purpose consistent with the intent, policies, and purposes of K.S.A. 40-2251, and amendments thereto. Whether or not a legitimate purpose exists may be determined by the commissioner of insurance.

(2) Each request for a compilation of data shall be reviewed by the commissioner of insurance to determine whether to approve or deny the request. A request for compilation of data may be denied by the commissioner of insurance for reasons including any of the following.

(A) The data is unavailable.

(B) The requested compilation is already available from another source.

(C) The requested compilation of data would endanger patient confidentiality.

(D) The commissioner lacks sufficient resources to fulfill the request.

(E) The request would disclose a trade secret.

(F) The requester has previously violated the rules for dissemination from the insurance database.

(G) The request is not a legitimate purpose.

(3) The requester may ask for compilations of data collected by and furnished to the commissioner of insurance in a specific manner or format not already used by the commissioner. This shall include any request for subsets of information already available from the commissioner in compiled form.

(4) The requester shall be notified by the commissioner of insurance in writing of its decision within 30 days. Each denial of a request shall include a brief explanation of the reason for the denial.

(5) Determination of a fee to be charged to the requesting person, organization, governmental agency, or other entity to cover the direct and indirect costs for producing compilations shall be made by the commissioner of insurance or designee in consultation with the commissioner. The fee shall include staff time, computer time, copying costs, and supplies. For charging purposes, each compilation shall be considered an original. The fee may be waived at the commissioner's discretion.

(c) No person, organization, governmental agency, or other entity receiving data from the commissioner shall redisclose or redistribute that information for commercial purposes. Any violation of this section shall result in denial of all further requests to the insurance database.

(d) Any publication using data from the insurance database shall include a written acknowledgment of the Kansas insurance department. A copy of any publication of data from the insurance database shall be sent to the commissioner of insurance before its publication. (Authorized by K.S.A. 1997 Supp. 40-2251 and K.S.A. 40-221; implementing K.S.A. 1997 Supp. 40-2251; effective Aug. 21, 1998.)

40-1-46. Privacy of consumer financial and health information. The national association of insurance commissioners' "privacy of consumer financial and health information regulation," as adopted by the national association of insurance commissioners on September 26, 2000, is hereby adopted by reference subject to the following exceptions: Sections 1 and 24 are not adopted by reference. This amended regulation shall be effective on and after February 1, 2002. (Authorized by K.S.A. 40-103 and K.S.A. 40-2404(15), as amended by L. 2001, ch. 202, sec. 1; implementing K.S.A. 40-2404(15), as amended by L. 2001, ch. 202, sec. 1; effective July 1, 2001; amended March 1, 2002.)

40-1-47. Insurance companies; deposits; requirements. (a) For the purposes of this regulation, the following terms shall be defined as follows:

(1) "Custodial account" means an account established by written agreement between a company and a custodian pursuant to K.S.A. 40-229a and amendments thereto.

(2) "Custodial agreement" means a written agreement entered into between a company and a custodian pursuant to K.S.A. 40-229a and amendments thereto.

(3) "Custodian" means an institution meeting the requirements of subsection (b) of this regulation that has entered into a custodial agreement with a company.

(4) "Custodied securities" means securities held by the custodian or held for the account of the custodian in an authorized clearing corporation, in the federal reserve bank book-entry system, or in a United States bank.

(5) "Securities" means all assets that may be used to satisfy the deposit requirements of K.S.A. 40-229a and amendments thereto, including mortgages, certificates of deposit, cash, securities of the kind or character in which the company is

allowed to invest its funds, and investment income due and accrued on custodied securities that are not in default. "Securities" shall not include real estate, other than the company's interest as a mortgagee or secured party.

(b) To qualify as a custodian, pursuant to this regulation, an institution shall meet all of the following requirements:

(1) It shall be a financial institution as defined in K.S.A. 40-229a(e)(2) and amendments thereto.

(2) It shall possess a combined capital and surplus that at all times equals or exceeds $500,000.

(3) It shall maintain blanket bond coverage relating to the custodied securities with limits satisfactory to the commissioner.

(c) Securities deposited as described in K.S.A. 40-229a, and amendments thereto, shall include an executed custodial agreement in writing that provides the following:

(1) That the custodian shall be obligated to indemnify the insurance company for any loss of securities of the insurance company in the bank or trust company's custody occasioned by the negligence or dishonesty of the bank or trust company's officers or employees, or burglary, robbery, holdup, theft, or unexplained disappearance, including losses by damage or destruction;

(2) that if there is a loss of the securities for which the bank or trust company is obligated to indemnify the insurance company, the securities shall be promptly replaced, or the value of the securities and the value of any loss of rights or privileges resulting from the loss of securities shall be promptly replaced;

(3) that the bank or trust company shall not be liable for any failure or delay in taking any action required to be taken in the event of any of the following:

(A) War, whether declared or not and including existing wars;

(B) revolution;

(C) insurrection;

(D) riot;

(E) civil commotion;

(F) act of God;

(G) accident;

(H) fire;

(I) explosion;

(J) stoppage of labor, strikes, or other differences with employees;

(K) laws, regulations, orders, or the acts of any governmental authority; or

(L) any other cause whatever beyond its reasonable control;

(4) a provision stating where the securities held in physical form are located;

(5) a provision stating that the custodian's records shall identify the following:

(A) The name of the clearing corporation, securities depository, or United States bank;

(B) the location of the securities; and

(C) if held through an agent, the name of the agent;

(6) a provision stating that all custodied securities that are registered shall be registered under the name of any of the following:

(A) The company;

(B) a nominee of the company;

(C) the custodian or its nominees, if held in a securities depository;

(D) the securities depository or its nominee; or

(E) the clearing corporation or its nominee, if held in an authorized clearing corporation as provided in K.S.A. 40-2a20 and K.S.A. 40-2b20 and amendments thereto;

(7) a provision stating that the obligations of the custodian of securities shall not be released as a result of a clearing corporation or a securities depository holding the custodied securities;

(8) a provision stating that securities may be held under a "filing of security by issuer" (FOSBI) system, in fungible or commingled form as part of a "jumbo" certificate;

(9) a provision stating that the custodian bank or trust company may utilize the federal reserve system book-entry program; and

(10) a provision stating that the custodian bank or trust company may utilize the facilities of a securities depository or an authorized clearing corporation.

(d) A company may satisfy its deposit requirement by depositing assets with a custodian bank having its principal place of business in Kansas, pursuant to a written agreement with the custodian bank. If otherwise authorized by the laws of this state, the custodian bank may utilize the services of another United States bank to physically hold custodied securities and to prepare any reports required by the custodial agreement, on behalf of the custodian. The custodian bank shall remain responsible for the safekeeping of all custodied securities, the submission of any reports required by this regulation, and compliance with all other requirements imposed by K.S.A. 40-

229a, and amendments thereto, and this regulation.

(e) The custodian shall ensure the following:

(1) That the custodial account is titled to indicate that the custodied securities are held in trust for the use and benefits of the company;

(2) during the course of the custodian's regular business hours, the commissioner or the commissioner's representative and authorized employees and representatives of the company are entitled to examine on the premises of the custodian the custodian's records relating to custodied securities of the company;

(3) that the custodial agreement and all amendments to it are submitted by the company to the commissioner for the commissioner's review and approval before execution. The custodial agreement and all amendments to it shall be deemed approved unless disapproved by the commissioner within 30 days of the date of the agreement and any amendments received by the commissioner. The custodial agreement may be terminated only with the prior approval of the commissioner; and

(4) that the commissioner or his duly authorized assistant commissioner or representative may at any time inspect the securities held under a custodian agreement.

(f) The custodial agreement may contain additional provisions if these provisions are not in conflict with this regulation.

(g) In addition to the joint custody receipt arrangement recognized in K.S.A. 40-229a and amendments thereto, the custodian may utilize a custodial or controlled account arrangement pursuant to K.S.A. 40-229a and amendments thereto. Within the custodial or controlled account arrangement, the custodian shall meet the following requirements:

(1) The custodian shall not allow the company to withdraw or exchange securities that would at any time reduce the aggregate value of the securities held by the custodian in the company's custodial account to a value less than the minimum aggregate value of securities currently in effect, as determined under subsection (h) of this regulation. The aggregate value of securities on deposit with the custodian shall be determined by utilizing the same procedure for valuing securities as that used by the commissioner for valuing other deposits made pursuant to K.S.A. 40-229a and amendments thereto. The custodian may effect a transfer of securities that would reduce the aggregate value of the securities held by the custodian in the company's custodial account to a value less than the minimum aggregate value of securities currently in effect if the securities or their proceeds are immediately transferred directly by the custodian to the commissioner for deposit pursuant to K.S.A. 40-229a and amendments thereto and the commissioner authorizes the transfer in writing.

(2) The custodian shall, within 30 days after the last day of each month, provide evidence to the commissioner in a form acceptable to the commissioner that the aggregate value of securities held by the custodian for the company on the last day of the prior month was at least equal to the minimum aggregate value of securities effective on this date, as determined under subsection (h) of this regulation. This evidence shall include the following information relevant to each type of security:

(A) The balance in any cash account;

(B) the name of the issuer;

(C) a description of the security;

(D) the number of shares;

(E) the face value;

(F) the form of ownership registration;

(G) the location of the security;

(H) the original cost;

(I) the current market value; and

(J) the unpaid balance.

(h) The minimum aggregate value of securities shall be stated in the original custodial agreement referred to in subsection (g) of this regulation but may be changed with the written consent of the commissioner. The company may deposit securities in, withdraw securities from, or exchange securities in the custodial account subject to the provisions of subsection (g) of this regulation.

(i) Each adjudicative proceeding conducted by the insurance commissioner shall be conducted in accordance with the Kansas administrative procedure act, K.S.A. 77-501, et seq., and amendments thereto. After providing notice and an opportunity for hearing, either or both of the following actions may be taken by the commissioner:

(1) Termination of the acceptance of deposits made with any custodian not in compliance with the requirements of this regulation; or

(2) acquisition of custody or otherwise assumption of control of the custodied securities, registration, delivery, or other disposition as may be ordered by the commissioner and deemed appro-

priate under the circumstances if either of the following conditions is met:

(A) The custodian fails to provide information, or the commissioner has reason to believe that the custodian may be insolvent or that the custodian's financial condition endangers the custodied securities.

(B) The custodian fails to provide the evidence of the aggregate value of the securities as described in subsection (g) of this regulation and otherwise endangers the custodied securities. (Authorized by K.S.A. 40-103, 40-229a; implementing K.S.A. 40-229a; effective May 10, 2002.)

40-1-48. Risk-based capital instructions for health organizations. The following document prepared by the national association of insurance commissioners and dated November 8, 2007 is hereby adopted by reference:

"2007 NAIC health risk-based capital report including overview and instructions for companies, as of December 31, 2007," except the letter dated November 8, 2007 to health risk-based capital subscribers from Crystal Brown; the health risk-based capital newsletter, volume 10.1, dated July 2007 and updated December 3, 2007; pages i and ii; and the health risk-based capital forecasting spreadsheet instructions. (Authorized by K.S.A. 40-2d29; implementing K.S.A. 40-2d02(a) and 40-2d03(a); effective Dec. 28, 2001; amended July 5, 2002; amended Oct. 17, 2003; amended April 23, 2004; amended March 17, 2006; amended Dec. 1, 2008.)

40-1-49. Stop loss or excess loss insurance; policy standards. (a) As used in these regulations, these terms shall have the following meanings:

(1) "Aggregate attachment point" means the dollar amount per plan beyond which the carrier issuing the policy assumes some or all of the plan's liability for payment of covered services or benefits.

(2) "Expected claims" means the amount of covered claims under the plan that is projected to be incurred by a policyholder under the plan.

(3) "Specific attachment point" means the dollar amount per person or participant, for each policy year beyond which the carrier issuing the insurance coverage assumes some or all of the plan's liability for payment of covered services or benefits.

(b) Each insurer or other entity licensed to sell insurance in this state shall comply with the following requirements for stop loss or excess loss insurance issued to a small employer as defined by K.S.A. 40-2209d(u), and amendments thereto:

(1) Each stop loss or excess loss policy shall be issued to and shall insure the plan or the plan's sponsor, not the individual participants.

(2) Payment by the insurer shall be made to the plan's sponsor or the policyholder, not the employees, members, participants, or providers.

(3) The specific attachment point for stop loss or excess loss coverage shall be no less than $10,000 per covered person or individual participant.

(4) The aggregate attachment point for stop loss or excess loss coverage shall be no less than 120 percent of expected claims.

(5) Each stop loss or excess loss policy shall contain a provision that the bankruptcy or insolvency of the plan or plan's sponsor does not relieve the stop loss or excess loss insurer from its obligation to pay claims under the stop loss or excess loss policy.

(6) In the case of incurred basis stop loss or excess loss coverage, the claims settlement period shall be no less favorable than a period in which claims are incurred in 12 months and paid in 13 months.

(c) Any stop loss or excess loss insurance policy not in compliance with this regulation shall be disapproved for sale or issue in this state. (Authorized by K.S.A. 40-103 and 40-2201(b); implementing K.S.A. 40-2201(b); effective Oct. 18, 2002.)

40-1-50. Insurance scoring; definitions; requirements. (a) As used in this regulation and K.S.A. 40-5101 through K.S.A. 40-5114 and amendments thereto, these terms shall have the following meanings:

(1) "Farmowner insurance policy" means a policy that provides coverage for a dwelling and its contents, barns, stables, and other buildings. This term shall include liability coverage.

(2) "Insurer" means an insurance company.

(3) "Policy" means any personal insurance or individual farmowner insurance policy.

(4) "Premium charge" means the payment required for an insurance policy as determined by rates and rating factors.

(5) "Rerate" means to calculate premiums based on rates, rating factors, or rating procedures filed with the Kansas insurance department as re-

quired by K.S.A. 40-951 through K.S.A. 40-967 and amendments thereto.

(6) "Reunderwrite" means to reexamine insurance risks to determine whether or not to renew policies.

(7) "Third party" means any person or entity that creates an insurance score.

(8) "Underwriting" means examining, accepting, or rejecting insurance risks.

(b) No insurer authorized to write business in the state of Kansas shall use credit information or an insurance score that has an adverse premium or coverage impact on an insured, unless all of the following conditions are met:

(1) The insurer has considered applicable factors other than credit.

(2) The insurer has documented the factors considered.

(3) The insurer provides the insured with each reason for the change in the premium or coverage.

(c) Each insurer using credit information for the purpose of rating shall have specific, written criteria governing how credit information is utilized by the insurer in underwriting, tier placement, and insurance scoring.

(d) If an insurer takes an adverse action against a consumer, the insurer shall perform the following:

(1) Maintain evidence of the notice to the consumer and a record of the contents of the credit information used, for a minimum of five years after the adverse action was taken;

(2) provide to the consumer a written, electronic, or oral notice and an explanation. If an oral notice is given, the notice shall be followed by a written or electronic notice and an explanation to the consumer pursuant to K.S.A. 40-5107, and amendments thereto; and

(3) provide underwriting guidelines to the department upon request. All underwriting guidelines shall be considered trade secrets and confidential under the Kansas open records act.

(e) Any insurer may require that a consumer provide documentation to establish the existence and duration of personal circumstances justifying that certain adverse credit information not be used. (Authorized by K.S.A. 40-103 and K.S.A. 2003 Supp. 40-5113; implementing K.S.A. 40-222(a) and K.S.A. 2003 Supp. 40-5102, K.S.A. 2003 Supp. 40-5104, K.S.A. 2003 Supp. 40-5107, K.S.A. 2003 Supp. 40-5108, K.S.A. 2003 Supp. 40-5112, and K.S.A. 2003 Supp. 40-5113; effective, T-40-2-19-04, Feb. 19, 2004; effective July 2, 2004.)

40-1-51. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-229; effective April 9, 2004; amended Dec. 2, 2005; revoked Sept. 14, 2007.)

Article 2.—LIFE INSURANCE

40-2-1. (Authorized by K.S.A. 40-103; effective Jan. 1, 1966; amended May 1, 1975; revoked May 1, 1979.)

40-2-2. (Authorized by K.S.A. 40-103, 40-216; effective Jan. 1, 1966; revoked Jan. 1, 1974.)

40-2-3. (Authorized by K.S.A. 40-103, 40-216, 40-2208, K.S.A. 1965 Supp. 40-401, 40-428(e); effective Jan. 1, 1966; revoked May 1, 1986.)

40-2-4. (Authorized by K.S.A. 40-103; effective Jan. 1, 1966; amended Jan. 1, 1969; amended, E-76-29, June 19, 1975; amended May 1, 1976; revoked May 1, 1986.)

40-2-5. (Authorized by K.S.A. 40-103, 40-216, 40-415, 40-434; effective Jan. 1, 1966; revoked May 1, 1986.)

40-2-6. (Authorized by K.S.A. 40-103, 40-235, 40-2401 *et seq.*; effective Jan. 1, 1966; amended Jan. 1, 1971; revoked May 1, 1986.)

40-2-7. Life insurance companies and fraternal benefit associations; lapse of policies providing for automatic term insurance or fractional paid-up insurance; notice to policyholders required. (a) Each life insurance company and fraternal benefit association writing contracts of insurance on Kansas citizens shall give written notice to its insureds upon the lapse of any insurance policy which provides for either automatic term insurance or fractional paid-up insurance.

(b) The following rules of notice shall be observed:

(1) The notice shall be sent to residents of Kansas only.

(2) The notice shall be sent within six months after the due date of the premium in default.

(3) The notice shall be sent only if paid-up or extended insurance value was available at date of lapse.

(4) A notice regarding lapse of industrial insurance shall be sent only if the premiums have been paid for three years or more.

(5) The notice shall show the amount of fractional paid-up insurance.

(6) A notice regarding lapse of extended term insurance need not show the amount of insurance. However, the notice shall show:

(A) The date of expiration; or

(B) the date of lapse and period of extension. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-410, 40-411; effective Jan. 1, 1966; amended May 1, 1986.)

40-2-8. Life insurance policies; premium deposit fund provisions; requirements. Premium deposit fund provisions shall not be included in or attached to life insurance contracts issued in this state unless:

(a) The provisions allow withdrawal of all or any part of the fund at the request of the policy owner; and

(b) the withdrawal may be effected not later than the next succeeding policy anniversary date. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-401; effective Jan. 1, 1966; amended May 1, 1986; amended May 1, 1987.)

40-2-9. Life insurance companies; extra premium payments; limits. Premium deposit fund provision and other funds which provide for extra premium payments exceeding the cost of insurance, shall be limited to an amount which, together with the policy reserve, would pay the net single policy premium. An insurance company authorized to do business in the state of Kansas shall not be authorized to accept an excess payment. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-401; effective Jan. 1, 1966; amended May 1, 1986.)

40-2-10. Same; deficiency reserves; requirements. Any life insurance company may establish deficiency reserves when gross premium charges are less than net premiums. However, the company shall give the department a complete description of the reserve establishment. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-409; effective Jan. 1, 1966; amended May 1, 1986.)

40-2-11. Life insurance policies; "wholesale" or "franchise" plan; requirements. (a) Definitions.

(1) "Wholesale" or "franchise" insurance means a life insurance plan under which a number of individual life insurance policies are issued at special rates to a group of five or more persons.

(2) "Special rate" means any rate lower than the rate shown in the issuing insurance manual for individual policies of the same type and class.

(3) "Employee" means the officers, managers, employees, and retired employees of the employer and the individual proprietor or partner, if the employer is an individual proprietorship or partnership.

(b) "Wholesale" or "franchise" life insurance premiums may be paid to the insurer periodically by:

(1) the employer, with or without payroll deductions;

(2) the insured;

(3) an association or union acting for its members; or

(4) designated persons acting on behalf of the employer, association, or union.

(c) Each life insurance policy form issued on the "wholesale" or "franchise" plan may be approved by the commissioner only if the policy is issued to:

(1) Five or more employees of a common employer or affiliated employers, including a governmental agency or department;

(2) five or more members of a trade or professional association, a labor union, or an association of members in the same or related occupations if the organizations have a constitution or by-laws and are formed in good faith for purposes other than obtaining insurance; or

(3) five or more debtors of a common creditor or affiliated creditors.

(d) (1) "Wholesale" or "franchise" life plan policies shall be issued in the same form as an individual policy, varying only in amounts and type of coverage.

(2) Any "wholesale" or "franchise" life policy, issued to an individual may be cancelled if the insured member or eligible employee no longer qualifies because of job termination or another reason. The cancellation shall provide for conversion to a level premium life policy as follows:

(A) Each person no longer qualifying shall be entitled to an individual policy of life insurance without providing evidence of insurability and without disability or other supplementary benefits within 31 days after the cancellation.

(B) The insurance shall be in an amount that does not exceed the amount of insurance that was cancelled. The insurance shall be offered at the insurers' customary rate, applicable to the form and amount of the individual policy, to the class

of risk to which the person belonged, and to the person's attained age on the effective date of the policy issued at the time of conversion. The policy shall be on any form, except term insurance, customarily issued by the insurer.

(e) Existing "wholesale" or "franchise" policies may continue in force whether or not they meet the standards of this regulation and may be continued for persons currently insured. New "wholesale" or "franchise" life insurance policies shall not be written unless qualified under this regulation. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-420; effective Jan. 1, 1967; amended Jan. 1, 1968; amended May 1, 1979; amended May 1, 1986.)

40-2-12. Replacement of life insurance and annuities. (a) Definitions.

(1) "Agent" means each agent, broker, or other person representing an insurer in the sale of any type of policy.

(2) "Company" or "insurer" means each company, society, association or other financial institution which issues a policy subject to the supervision of the Kansas insurance department.

(3) "Life insurance" means each life insurance policy, annuity, or variable annuity contract, unless specifically exempted in subsection (b).

(4) "Substantial cash values" means each transaction in which an amount exceeding 50 percent of the tabular cash value may be released on one or more of the existing policies.

(5) "Substantial borrowings" means each transaction in which an amount exceeding 50 percent of the tabular cash value may be borrowed on one or more existing policies.

(6) "Securities," as used in this regulation, shall not include any insurance or endowment policy, or annuity contract under which an insurance company promises to pay a fixed or variable sum of money either in a lump sum or periodically for life or for some other specified period.

(7) "Replacement" means each transaction in which new life insurance may be purchased from an agent who knows, or reasonably should know that, as a part of the transaction or in consequence of it, a previously existing life insurance has been or is likely to be:

(A) Lapsed or surrendered;

(B) converted into paid-up insurance, continued as extended term insurance or another form of non-forfeiture benefit;

(C) converted to effect a reduction either in the amount of the existing life insurance, or in the period of time the existing life insurance will continue in force;

(D) reissued with a reduction in amount so that substantial cash values are released; or

(E) assigned as collateral for a loan or subjected to substantial borrowing of loan values in single or multiple transactions.

(8) "Sales proposal" means individualized, written sales aids. Sales aids of a general nature, which are maintained in the insurer's advertising compliance file, shall not be considered a sales proposal.

(b) This regulation shall not apply when:

(1) The application for the new life insurance is made to the same insurer that issued the existing life insurance, and a contractual policy change or conversion privilege is being exercised;

(2) the new life insurance is provided under:

(A) A group life insurance policy; or

(B) policies covering employees of an employer, debtors of a creditor, or members of an association, which are distributed on a mass merchandising basis and administered by group-type methods;

(3) the existing life insurance is a non-convertible term policy with five years or less to expire and which cannot be renewed;

(4) the solicitation is made by direct mail and:

(A) All sales material is standard and printed;

(B) the insurance company notifies the existing insurance company within three business days that the proposed insured has answered "yes" to the replacement question in the application; and

(C) concurrent with the notice to the existing company, the insurance company mails to the applicant a copy of the "notice to applicant regarding replacement of life insurance" described in subsection (h); or

(5) the policy is issued in connection with a pension, profit sharing, an individual retirement account or other benefit plan qualifying for an income tax deduction of premiums.

(c) Each life insurance agent shall:

(1) Obtain a statement signed by the applicant as a part of each life insurance application as to whether the new insurance will replace existing life insurance; and

(2) submit to the insurer in connection with each life insurance application a statement as to whether, to the best of the agent's knowledge, a life insurance replacement is involved in the transaction.

(d) When a replacement is involved, each life insurance agent shall:

(1) Include as part of each application a list of all existing life insurance policies to be replaced and the name of each insurer which issued the insurance being replaced;

(2) present to the applicant, when the application is submitted, a copy of each sales proposal used, and a "notice to applicants regarding replacement of life insurance" described in section (h) in a form acceptable to the commissioner. The agent shall leave the forms with the applicant after explaining their content;

(3) submit with the application a copy of each sales proposal used; and

(4) have the applicant acknowledge receipt of the "notice to applicant regarding replacement of life insurance."

(e) Each insurer shall:

(1) Inform its field representatives of the requirements of this regulation;

(2) require with each application a statement signed by the applicant as to whether the insurance will replace existing life insurance; and

(3) require in connection with each application for life insurance a statement signed by the agent as to whether, to the best of the agent's knowledge, a life insurance replacement is involved in the transaction.

(f) When a replacement is involved, the replacing insurer shall:

(1) Require with each application a list prepared by the agent of all existing life insurance policies to be replaced;

(2) obtain a copy of any sales proposal used, proof of the receipt by the applicant of the "notice to applicant regarding replacement of life insurance," and the name of each insurer whose insurance is being replaced;

(3) within three working days, notify each insurer whose insurance is being replaced by another insurer;

(4) delay, if it is not the existing insurer, policy issuance for 20 days after sending the notification required by subparagraph (3). The replacing insurer may issue its policy immediately when:

(A) The policy or a separate written notice states that, except as provided in K.A.R. 40-2-15 with respect to adjustments necessary to reflect investment risk on variable annuity contracts and variable life insurance polices, the applicant has a right to an unconditional refund of all premiums paid, within 20 days after delivery of the policy; and

(B) notice to the existing insurer is sent within three working days of the date its policy is issued;

(5) maintain copies of each sales proposal used, proof of receipt by the applicant of the "notice to applicant regarding replacement," and the applicant's signed statement with respect to replacement, in its home office for at least three years or until the conclusion of the next succeeding regular examination by the insurance department of its state of domicile, whichever is later. Each insurer receiving notice that its existing insurance may be replaced shall maintain a copy of the notice, indexed by insurer, for three years after receipt or until the conclusion of the next regular examination conducted by the insurance department of its state of domicile, whichever is later; and

(6) either by inclusion in the replacement policy or by a rider attached thereto, provide that the new life insurance issued by the replacing insurer will not be contestable by the replacing insurer, in the event of the insured's death, to any greater extent than the replaced life insurance would have been contestable by the insurer providing the replaced coverage had a replacement not occurred. Subsection (f) (6) shall not apply to any amount of insurance provided by the replacement policy which exceeds the amount of insurance provided by the replaced policy.

(g) With the exception of the reference to a comparative information form, the forms set forth in exhibits A, B, and C of the national association of insurance commissioners' model life insurance replacement regulation, December 1978 edition, are hereby adopted by reference. Equivalent forms may be adopted with the prior approval of the insurance commissioner. If the forms adopted by reference require modification for replacements involving annuity contracts or contracts sold by direct mail methods, each company shall modify the form and submit the modified form to the insurance commissioner for approval. A copy of the modified forms shall be filed with the insurance commissioner.

(h) If an agent, who holds both a life insurance license and a securities license, proposes to sell securities to a policyholder which will result in situations set forth in paragraph (7) of subsection (a), the agent shall give written notice to the policyholder before consummating the proposal. Each written notice shall:

(1) Be dated and signed by the licensed agent, and state the agent's address;

(2) state the name and address of the policyholder;

(3) describe the insurance which has been or is to be affected, including the policy number, amount of insurance, plan of insurance, issue age, effective date, and the total premium;

(4) state how the insurance will be affected, the amount of cash value affected and the facts which support replacement; and

(5) list the company or companies involved.

(i) Each agent, who holds both a life insurance license and a securities license, shall keep a file containing a copy of each written notice. The agent shall keep a copy of each notice for three years. The file shall be subject to inspection and review by the insurance department, upon written request.

(j) When any licensed agent solicits life insurance in connection with the sale of securities not prohibited by K.S.A. 40-232, this agent shall, in addition to complying with the requirements of subsections (c) and (d), submit a copy of the notice required by subsection (i) to the insurer. Each notice shall be attached to and become a part of exhibit A referenced in section (g) of this regulation.

(k) Any violation of this rule shall be presumed to constitute a misleading representation for the purpose of inducing or tending to induce an insured to lapse, forfeit or surrender the insured's existing insurance. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 1991 Supp. 40-2404; effective Jan. 1, 1971; amended Jan. 1, 1972; amended, E-72-20, Sept. 1, 1972; amended Jan. 1, 1973; amended Feb. 15, 1977; amended May 1, 1982; amended May 1, 1983; amended May 1, 1986; amended May 1, 1987; amended May 15, 1989; amended Jan. 4, 1993.)

40-2-13. Life insurance policies; promissory notes and installment contracts; college students; requirements. In addition to the provisions of K.S.A. 40-283a, the following requirements shall apply to premium financing arrangements between an insuror or agent and the insured for the first premium payable on any life insurance policy sold to any college student.

(a) Each premium financing arrangement shall be set out in the application over the applicant's signature and shall include the total amount of the loan, the amount of any down payment made to an agent at the time of sale, and the unpaid balance.

(b) If a note or installment contract is used to finance less than the full first year premium, the balance shall be paid by the applicant when the application is taken.

(c) A copy of the note or installment contract and any assignment shall be attached to the policy. In lieu of attachment, the policy may contain a provision or endorsement which describes the financing arrangement.

(d) Upon delivery, a policy receipt or acceptance form shall be executed which states that:

(1) The policy has been issued as represented; and

(2) The insured acknowledges and understands the provisions and obligations of the financial indebtedness incurred.

(e) The receipt or acceptance form required by subsection (d) above shall be registered in the home office by a number corresponding to the policy number.

(1) The receipt shall be sent with the policy at time of delivery only; and

(2) the receipt or acceptance forms shall not be made available as supplies to field representatives or agents, but shall be furnished from the home office in transmittal of the policy to the writing agent.

(f) Promissory notes shall not be sold or transferred by the payee (agent). Commissions on the sale shall not be paid to the agent until the policy receipt or acceptance form has been received in the home or executive office of the company.

(g) The note purchaser, assignee, or company shall notify the notemaker (insured) and all comakers regarding the purchase or transfer of the note, after the purchase or transfer, inviting any questions about the note or the policy which is used as collateral security for the note.

(h) If, at the time the policy receipt or acceptance form is presented with the policy to the applicant for signature and the applicant decides that he or she does not desire the plan, the policy shall be returned to the company with a signed request for release. The policy and note shall be canceled, the applicant shall be released from liability, and when applicable, the down payment shall be refunded.

(i) If a sales presentation is made for an amount of insurance greater than that sold, an appropriate explanation shall be given to the insured when the policy is delivered. (Authorized by K.S.A. 40-103;

implementing K.S.A 40-283a; effective Jan. 1, 1972; amended Feb. 15, 1977; amended May 1, 1986.)

40-2-14. Life insurance and annuities; deceptive practices; requirements; prohibitions. (a) This regulation shall apply to each solicitation, negotiation, or procurement of life insurance or annuities occurring within this state. This regulation shall apply to each authorized issuer of life insurance or annuity contracts. This regulation shall not apply to invitations to inquire about an insurance product if the invitations do not constitute a solicitation of insurance. The policy summary required by this regulation shall not apply to annuities, variable life insurance, life insurance policies issued in connection with pension and welfare plans subject to the employee retirement income security act of 1974, credit life insurance, or group life insurance.

(b) In selling life insurance or annuities, an agent shall, at the beginning of a solicitation, inform the prospective purchaser that he or she is acting as an insurance agent. Each applicant shall be furnished a policy summary at or before the time of policy delivery. For the purpose of this regulation, a policy summary means a written statement describing the elements of the policy. The summary shall include the following information:

(1) The name and address of the insurance agent or if an agent is not involved, the name, address and telephone number of the person designated to receive inquiries regarding the policy summary;

(2) the full name and home office or administrative office address of the company writing the life insurance or annuity policy;

(3) the generic name of the basic policy or contract and each rider;

(4) amounts, where applicable, for the first five policy years, the tenth and twentieth policy years, and for at least one age from 60 through 65 or at maturity as follows:

(A) The annual premium for the basic policy;

(B) the annual premium for each optional rider;

(C) the guaranteed amount payable upon death, at the beginning of the policy year, for all causes of death other than suicide, or other specifically enumerated exclusions. The guaranteed amount payable under the basic policy and each rider shall be listed separately;

(D) the total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider;

(E) the cash dividends payable to the end of the year with values shown separately for the basic policy and each rider, except that dividends need not be displayed beyond the twentieth policy year; and

(F) the guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values above;

(5) (A) if a policy summary includes dividend illustrations, a statement that dividends are based on the company's current dividend scale and are not guaranteed;

(B) if a policy summary includes interest rate illustrations, a statement that projected or assumed interest rates are based on current interest rates and cannot be guaranteed;

(6) the effective policy loan annual percentage interest rate, if the policy contains a loan provision. The policy summary shall state whether this rate is applied in advance or in arrears. If the policy loan interest rate is variable, the policy summary shall include the maximum annual percentage rate;

(7) the date on which the policy summary is prepared; and

(8) a statement to the effect that the presentation does not recognize that, because of interest, a dollar in the future has less value than a dollar today, unless the policy summary includes index figures which recognize the time-value of money. If index figures are included in the policy summary, the applicant shall receive written notification at the time the policy summary is delivered that those figures may be used only for comparing the relative costs of similar policies.

The policy summary shall consist of a separate document. All disclosure information required shall be set out in a manner that will not minimize or render any portion of it obscure. Amounts which remain level for two or more years may be represented by a single number if it clearly indicates what amounts apply to each policy year. Amounts in paragraph (4) of this subsection shall be listed in total. If multiple insureds are covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured, or for each class of insureds when death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

(c) The following shall be deemed prohibited, unfair or deceptive acts or practices in the selling of insurance:

(1) Making a misrepresentation or false, deceptive or misleading statement;

(2) using comparisons or analogies or manipulating amounts and numbers in a way that will mislead the prospective purchaser concerning the cost of the insurance protection coverage;

(3) referring to an insurance premium as a deposit, an investment, a savings or the use of other phrases of similar import when referring to an insurance premium. This subsection shall not prohibit discussion of the savings values of a life insurance policy having cash values;

(4) describing the policy dividend as other than a refund or return of part of the aggregate premiums paid to the company, which is not guaranteed and which is dependent on the investment earnings, mortality experience and expense experience of the company; and

(5) recommending to a prospective purchaser the purchase or replacement of any life insurance policy or annuity contract with reasonable grounds to believe that the recommendation is unsuitable for the applicant on the basis of information furnished by this person, or otherwise obtained.

(d)(1) No annuity shall be advertised or solicited using any language in advertisements or solicitation material of any kind that refers to the annuity as being "risk free," or a similar connotation.

(2) At the time an application is taken for a single premium deferred annuity, the disclosure form prescribed by the commissioner shall be executed by the applicant and the selling agent and attached to the application. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-2404 as amended by L. 1987, Ch. 171, Sec. 1; effective Jan. 1, 1974; amended May 1, 1981; amended May 1, 1982; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988.)

40-2-14a. Life insurance and annuities; recommendation standards. The Kansas insurance department's "opinion and memorandum regarding annuity transactions," dated June 8, 2005, is hereby adopted by reference. (Authorized by K.S.A. 40-103 and 40-2404a; implementing K.S.A. 40-222, 40-2403, and K.S.A. 2004 Supp. 40-2404; effective May 20, 2005; amended Dec. 2, 2005.)

40-2-14b. (Authorized by K.S.A. 40-103 and 40-2404a; implementing K.S.A. 40-2403 and K.S.A. 2002 Supp. 40-2404; effective May 20, 2005; revoked Dec. 2, 2005.)

40-2-15. Individual life insurance policies; right to return policy. (a) Each individual life insurance policy and annuity contract issued for delivery in this state shall contain a notice.

(b) The notice shall be printed on or attached to the first page of the policy. The notice shall be printed in not less than 10 point type and shall be printed in a bold face type or in some other manner that distinguishes it from the print otherwise appearing in the policy. It shall state that the person to whom the policy is issued shall be permitted to return the policy or contract within at least 10 days of its delivery to the purchaser and, except with respect to variable annuity contracts and variable life insurance policies as defined in K.A.R. 40-15-1 and K.A.R. 40-15a-1 respectively, have the total premium paid refunded if the purchaser is not satisfied. With respect to variable annuity contracts and variable life insurance policies, the person to whom the policy is issued shall be entitled to a premium refund equal to the sum of:

(1) The difference between the premiums paid, including any policy fees or other charges and the amounts allocated to any separate accounts under the policy; and

(2) the value of the amounts allocated to any separate accounts under the policy on the date the returned policy is received by the insurer or its agent.

(c) Each policy returned to the company or association at its home or branch office or to the agent through whom it was purchased shall be void. Each party shall be in the same position as if no policy had been issued. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 1990 Supp. 40-2404; effective Feb. 15, 1977; amended May 1, 1979; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 6, 1992.)

40-2-16. Life insurance and annuities; mortality tables; sexual distinctions; permits and prohibitions. (a) For each policy of life insurance delivered or issued for delivery in this state, the blended 1980 CSO and CET mortality tables A through G, adopted December 1983 and tables SA through SG and NA through NG adopted December 1986 by the national association of insurance commissioners, may be substi-

tuted for the 1980 CSO or CET table, with or without ten-year select mortality factors.

(b) It shall not be a violation of K.S.A. 40-2404(7) for an insurer to issue the same type of life insurance policy on both a sex-distinct and sex-neutral basis. (Authorized by K.S.A. 40-103, 40-428; implementing K.S.A. 40-428; effective, T-85-11, April 11, 1984; effective May 1, 1985; amended May 1, 1986; amended May 1, 1988.)

40-2-17. Life insurance and annuities; mortality tables; smokers and nonsmokers; permits and prohibitions. The national association of insurance commissioners' model regulation permitting smoker-non-smoker mortality tables, December 1983 edition, is adopted by reference subject to the following exceptions: (a) Sections 1, 2, 6 and 7 are not adopted; and

(b) Section 4 is amended by the addition of "428 of chapter 40, Kansas statutes annotated" immediately following the word "section" in paragraph A. (Authorized by K.S.A. 40-103; implementing K.S.A. 1984 Supp. 40-428(3-d); effective May 1, 1986.)

40-2-18. Annuities; mortality tables; permits and prohibitions; effective dates. The national association of insurance commissioners' model regulation for recognizing a new annuity mortality table, December 1983 edition, is hereby adopted by reference subject to the following exceptions: (a) Sections 1, 2, 6 and 7 are not adopted;

(b) Section 4.A. is amended by adding the date, July 1, 1982, as required;

(c) Section 4.B. is amended by adding the date, January 1, 1986, as required;

(d) Section 5.A. is amended by adding the date, July 1, 1982, as required; and

(e) Section 5.B. is amended by adding the date, January 1, 1986, as required. (Authorized by K.S.A. 40-103; implementing K.S.A. 1984 Supp. 40-428(d-3); effective May 1, 1986.)

40-2-19. Kansas life and health insurance guaranty association act; notice to policyholders; requirements. (a) The disclaimer required by L. 1986, Ch. 180, Sec. 15(c) shall be printed in bold face type and included on the face page of the summary document required by L. 1986, Ch. 180, Sec. 15(b). The disclaimer shall be entitled, "Disclaimer", and shall contain the following statements:

(1) the policy or contract, or a portion of it, may not be covered by the Kansas life and health insurance guaranty association;

(2) even if coverage is available for a portion of the policy, coverage is subject to significant limitations and exclusions and is conditioned upon continued residency in this state;

(3) the Kansas life and health insurance guaranty association or the Kansas insurance department will respond to any questions regarding the extent of coverage, if any, under the Kansas life and health insurance guaranty fund. The addresses of the association and insurance department shall follow this statement;

(4) the insurance company and agent are prohibited by law from using the existence of the Kansas life and health insurance guaranty association or its coverage to sell an insurance policy or contract; and

(5) the policy or contract holder should not rely on coverage from the Kansas life and health insurance guaranty association when selecting an insurance company.

(b) The notice to policyholders required by L. 1986, Ch. 180, Sec. 15(d) shall be printed in bold face type on a separate one page document not less than eight inches by five inches, with type not less than 10-point. The notice shall be entitled, "Special Notice", and shall contain the following information:

(1) Company name and address;

(2) a statement disclosing that all or a portion of the policy or contract is not guaranteed by the insurer or all or a portion of the risk under the policy or contract is borne by the policy or contract holder and is not covered by the Kansas life and health insurance guaranty association; and

(3) the statements required by subparagraphs (2), (3) and (4) of subsection (a) of this regulation. (Authorized by and implementing L. 1986, Ch. 180, Secs. 15(c) and (d); effective May 1, 1987.)

40-2-20. Life insurance; accelerated benefits; requirements and restrictions. (a) As used in this regulation, these terms shall have the following meanings:

(1) "Accelerated benefits" shall mean benefits that meet the following conditions:

(A) Are payable under an individual or group life insurance or annuity contract to a policyowner or certificate holder, during the lifetime of the insured for the occurrence of a qualifying condition;

(B) reduce the death benefit otherwise payable under the life insurance contract; and

(C) are payable upon the occurrence of a single qualifying condition, which results in the payment of a benefit amount fixed at the time of acceleration.

(2) "Qualifying condition" shall mean any of the following conditions:

(A) A medical condition that a health care provider licensed to practice medicine and surgery or osteopathy predicts will result in a limited life expectancy of 24 months or less;

(B) a medical condition that has required or requires extraordinary medical intervention, including a major organ transplant or continuous artificial life support, without which the insured would die;

(C) any condition that usually requires continuous confinement in an eligible institution as defined in the contract if the insured is expected to remain there for the rest of the insured's life;

(D) a medical condition that medical evidence indicates would, in the absence of extraordinary medical intervention, result in a limited life expectancy of 24 months or less. Such conditions may include any of the following:

(i) Coronary artery disease resulting in an acute infarction or requiring surgery;

(ii) a permanent neurological deficit resulting from a cerebral vascular accident;

(iii) end stage renal failure;

(iv) acquired immune deficiency syndrome;

(v) cancer;

(vi) paralysis;

(vii) blindness;

(viii) muscular sclerosis;

(ix) Alzheimer's disease;

(x) HIV;

(xi) anterior lateral sclerosis; or

(xii) severe burns; and

(E) any other condition approved by the commissioner as the basis for a qualifying event.

(3) "Commissioner" shall mean the commissioner of insurance, state of Kansas.

(b) Each accelerated benefit shall have a title printed on or attached to the first page of the policy or rider. The title shall describe the coverage provided and shall be followed or accompanied by a description of the coverage containing the phrase "accelerated benefit" or words of similar import.

(c) Each applicant shall be given a summary of the accelerated benefit provisions at or before the time an application is completed. For group policies, each certificate holder shall be given a copy of the summary with the certificate. This summary shall include the following:

(1) A brief description of the accelerated benefit and definitions of the qualifying conditions that would result in payment of the benefit;

(2) the existence and amount of any separately identifiable premium for the accelerated benefit and a description of any charge for administrative expense;

(3) a generic illustration numerically demonstrating the effect of the payment of a benefit on cash values, accumulation accounts, death benefits, premiums, policy loans, and policy liens;

(4) a statement that receipt of the accelerated benefit could be taxable;

(5) a statement that receipt of accelerated benefits could affect medicaid eligibility; and

(6) an acknowledgement, signed and dated by the agent and the applicant for the group or individual coverage, that the summary has been furnished. Each direct response insurer shall incorporate the summary and acknowledgement in the application or attach them to the application.

(d) Contract payment options shall include the option to take the benefit as a lump sum. The benefit shall not be made available as an annuity contingent upon the life of the insured.

(e) No restrictions shall be permitted on the use of the proceeds.

(f) If the accelerated benefit is offered without an additional premium, a separate written explanation of how the benefit is funded shall be filed with the commissioner and included with the summary.

(g) Each time an accelerated benefit is requested and whenever a previous summary becomes invalid, the irrevocable beneficiary and either the individual policyowner or group certificate holder shall be given a summary. This summary shall include statements meeting the following conditions:

(1) Warning that receipt of the accelerated benefit could be taxable and that assistance from a tax advisor is suggested;

(2) showing the effect that the payment of the benefit will have on cash values, accumulation accounts, death benefits, premiums, policy loans, and policy liens; and

(3) disclosing that receipt of accelerated benefit payments may adversely affect the recipient's

eligibility for medicaid or other government benefits or entitlements.

(h) Each time an accelerated benefit option is exercised, the policyowner and certificate holder shall be given an endorsement, rider, or schedule page that reflects any revisions to cash values, death benefits, accumulation accounts, premiums, policy loans, policy liens, and any other values that change as a result of the payment or payments.

(i) Insurers shall not unfairly discriminate among insureds with different or similar qualifying conditions covered under the policy. Insurers shall not apply any additional conditions to the payment of the accelerated benefits other than those conditions specified in the policy or rider.

(j) Any insurer may offer a waiver of premium for the accelerated benefit provision if a regular waiver of premium provision is not in effect. At the time the benefit is claimed, the insurer shall explain any continuing premium requirement to keep the policy in force.

(k) Accelerated benefits shall be funded by any of the following methods:

(1) Requiring the policyowner to pay an additional premium;

(2) utilizing the present value of the face amount of the policy if the following conditions are met:

(A) The present value calculation is based on an actuarial discount appropriate to the policy design;

(B) the interest rate used in the present value calculation is based on sound actuarial principles and disclosed in the contract or actuarial memorandum; and

(C) the maximum interest rate is no greater than the greater of either of the following:

(i) The current yield on 90-day treasury bills; or

(ii) the current maximum policy loan interest rate permitted by K.S.A. 40-420c and amendments thereto; or

(3) accruing an interest charge on the amount of the accelerated benefits at an interest rate based on sound actuarial principles and disclosed in the contract or actuarial memorandum and no greater than the greater of either of the following:

(i) The current yield on 90-day treasury bills; or

(ii) the current maximum policy loan interest rate permitted by K.S.A. 40-240c and amendments thereto.

(l) When an accelerated benefit is payable, no greater than a pro rata reduction in the cash value shall be made, unless the payment of the accelerated benefits and any accrued interest can be treated as a lien against the death benefit of the policy or rider. Therefore, access to the cash value may be restricted to any excess of the cash value over the sum of any other outstanding loans, and the lien and access to additional policy loans may be limited to the difference between the cash value and the sum of the lien and any other outstanding policy loans on the policy under which the accelerated benefits were paid.

(m) (1) If payment of an accelerated benefit results in a pro rata reduction in the cash value, the payment shall not be applied toward repaying an amount greater than a pro rata portion of any outstanding policy loans; or

(2) if the payment is considered a lien as provided in subsection (l), the insurance company may require any accelerated death benefit payment to be applied toward repaying the portion of any other outstanding policy loan that causes the sum of the accelerated death benefit and policy loan to exceed the cash value.

(n) The death benefit shall not be reduced more than the amount of the accelerated benefits after adjustment for any actuarial discount or accrued interest as provided in subsection (k) and any administrative expense charge required by policies providing accelerated benefits without an additional premium charge as disclosed on the summary required by subsection (c).

(o) If any death benefit remains after payment of an accelerated benefit, the accidental death benefit, if any, in a policy or rider shall not be affected by the payment of an accelerated benefit.

(p) The valuation method and assumptions used to produce the accelerated benefit provisions shall be filed with the insurance department with the related policy form or rider. The assumptions shall reflect the statutory mortality and interest rate assumptions for the life insurance provisions and appropriate assumptions for the other provisions incorporated in the policy or rider. Each insurer shall maintain in its files descriptions of the bases and procedures used to calculate benefits, which shall be made available for examination by the commissioner or a designee upon request.

(q) A qualified actuary shall describe the accelerated benefits, the risks, the expected costs, and the calculation of statutory reserves in an actuarial memorandum accompanying each filing of

accelerated benefits products with the commissioner. Each insurer shall maintain in its files descriptions of the bases and procedures used to calculate benefits payable under these provisions. These descriptions shall be made available for examination by the commissioner upon request.

(1) If benefits are provided through the acceleration of benefits under group or individual life policies or riders to these policies, policy reserves shall be determined in accordance with the standard valuation law. All valuation assumptions used in constructing the reserves shall be determined as appropriate for statutory valuation purposes by a member in good standing of the American academy of actuaries. Mortality tables and interest rates currently recognized for life insurance reserves by the national association of insurance commissioners may be used as well as appropriate assumptions for the other provisions incorporated in the policy form. The actuary shall follow both actuarial standards and certification for good and sufficient reserves. Reserves in the aggregate shall be sufficient to cover the following:

(A) Policies upon which no claim has yet arisen; and

(B) policies upon which an accelerated claim has arisen.

(2) For policies and certificates that provide actuarially equivalent benefits, no additional reserves shall be required to be established.

(3) Policy liens and policy loans, including accrued interest, shall represent assets of the company for statutory reporting purposes. For any policy on which the policy lien exceeds the policy's statutory reserve liability, the excess shall be held as a non-admitted asset.

(r) The accelerated benefit provision shall become effective for accidents on the effective date of the policy or rider and shall become effective for illness no more than 30 days following the effective date of the policy or rider. (Authorized by K.S.A. 40-103 and K.S.A. 40-401; implementing K.S.A. 40-401; effective, T-40-11-29-90, Nov. 29, 1990; effective April 15, 1991; amended Feb. 9, 2007.)

40-2-21. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-221a; effective Dec. 16, 1991; revoked June 20, 1997.)

40-2-22. (Authorized by K.S.A. 40-103, 40-404(e)(4) as amended by L. 1987, Ch. 162, Sec. 1; implementing K.S.A. 40-404(e) as amended by L. 1987, Ch. 162, Sec. 1; effective, T-88-44, Oct. 27, 1987; amended May 1, 1988; revoked May 10, 2002.)

40-2-23. Life insurance; preneed funeral contracts or arrangements; disclosure; requirements. (a) This regulation shall apply to any solicitation, negotiation or procurement occurring within this state with respect to life insurance or annuity contracts used to fund a preneed funeral contract or arrangement. As used in this regulation, the term "preneed funeral contract or arrangement" shall mean an agreement by or for an individual before that individual's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

(b) The following information shall be adequately disclosed at the time an application is made, prior to accepting the applicant's initial premium, for a preneed funeral contract or arrangement:

(1) The fact that a life insurance policy or annuity contract is involved or being used to fund a preneed funeral contract or arrangement;

(2) the nature of the relationship between the soliciting agent or agents, the provider of the funeral or cemetery merchandise or services, the administrator and any other person. This requirement shall not apply to officers, directors or bonafide employees of the funeral home or cemetery to which the original preneed funeral contract or arrangement applies;

(3) the relationship of the life insurance policy or annuity contract to the funding of the preneed funeral contract or arrangement and the nature and existence of any guarantees relating to such contract or arrangement;

(4) the impact on the preneed funeral contract or arrangement:

(A) Of any changes in the life insurance policy or annuity contract including but not limited to, changes in the assignment, beneficiary designation or use of the proceeds;

(B) of any penalties to be incurred by the policyholder as a result of failure to make premium payments; and

(C) of any penalties to be incurred or monies to be received as a result of cancellation or surrender of the life insurance policy or annuity contract;

(5) a list of the merchandise and services which are applied or contracted for in the preneed funeral contract or arrangement and all relevant in-

formation concerning the price of the funeral services, including a clear disclosure that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;

(6) all relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy or annuity contract and the amount actually needed to fund the preneed funeral contract or arrangement; and

(7) any penalties or restrictions, including but not limited to geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the preneed funeral contract or arrangement guarantee.

(c) In accordance with the provisions of K.S.A. 40-283a, the following requirements shall apply to premium financing arrangements between an insurer or agent and the insured for the first and any future premium payable on any life insurance policy or annuity contract sold to fund a preneed funeral contract or arrangement.

(1) Each premium financing arrangement and any renewal of such arrangement shall be signed by the applicant and shall include the total amount of the loan, the amount of any down payment made to an agent at the time of sale, and the unpaid balance.

(2) The policy shall contain a provision or endorsement which fully describes the financing arrangement.

(3) Upon delivery, a policy receipt or acceptance form shall be executed which states that the insured acknowledges and understands the provisions and obligations of the financial indebtedness incurred, including the fact that the premium financing arrangement cannot be effective for a term exceeding one year. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-283a, K.S.A. 1992 Supp. 40-2404(l); effective Nov. 29, 1993.)

40-2-24. Life and health reinsurance agreements. Sections 3, 4, 5, and 6 of the national association of insurance commissioners' "life and health reinsurance agreements model regulation," adopted by the NAIC on September 20, 1992, are hereby adopted by reference, subject to the following additions and exceptions:

(a) The formula in section 4A(7)(b) is hereby amended to read as follows: "The following formula shall be acceptable:

$$\text{"Rate} = \frac{2(I + CG)}{X + Y - I - CG}$$

"Where: 'I' is the net investment income [(exhibit 2, line 16, column 7 of the life and accident and health annual statement) or (underwriting and investment exhibit part 1, line 15, column 8 of the property and casualty annual statement)];

" 'CG' is the capital gains less capital losses [(exhibit 3, line 12, column 4 plus exhibit 4, line 10, column 4 of the life and accident and health annual statement) or (part 1A, line 10, column 7 of the property and casualty annual statement)];

" 'X' is the current year cash and invested assets [(page 2, line 11, column 4 of the life and accident and health annual statement) or (page 2, line 9, column 4 of the property and casualty annual statement)] plus investment income due and accrued [(page 2, line 17, column 4 of the life and accident and health annual statement) or (page 2, line 16, column 4 of the property and casualty annual statement)] less borrowed money [(page 3, line 22, column 1 of the life and accident and health annual statement) or (page 3, line 7, column 1 plus line 8, column 1 of the property and casualty annual statement)]; and

" 'Y' is the same as X but for the prior year."

(b) The first paragraph of section 4C(2) is hereby amended to read as follows: "Any increase in the surplus net of federal income tax resulting from arrangements described in subsection C(1) shall be identified separately on the insurer's statutory financial statement as a surplus item [(aggregate write-ins for gains and losses in surplus in the capital and surplus account, page 4, line 46, column 1 of the life and accident and health annual statement) or (aggregate write-ins for gains and losses in surplus in the capital and surplus account, page 4, line 30, column 1 of the property and casualty annual statement)], and recognition of the surplus increase as income shall be reflected on a net of tax basis in "commissions and expense allowances on reinsurance ceded" (page 4, line 5, column 1 of the life and accident and health annual statement) or in "other underwriting expenses incurred" (page 4, line 4, column 1 of the property and casualty annual statement) as earnings emerge from the reinsured business."

(c) Section 6 is hereby amended to read as follows: "Insurers subject to this regulation shall reduce to zero by December 31, 1997 any reserve credits or assets established with respect to reinsurance agreements entered into prior to the ef-

fective date of this regulation that, under the provisions of this regulation, would not be entitled to recognition of the reserve credits or assets. However, these reinsurance agreements shall have been in compliance with laws or regulations in existence immediately preceding the effective date of this regulation. (Authorized by K.S.A. 40-103; implementing K.S.A. 1996 Supp. 40-221a; effective April 11, 1997.)

40-2-25. Life insurance illustrations. The national association of insurance commissioners' "life insurance illustrations model regulation," January 1996 edition, is hereby adopted by reference, subject to the following alterations.

(a) Section 3(E) shall be inserted and shall read as follows:

"If a policy change requiring underwriting or a sales effort is made to a policy issued prior to the effective date of this regulation and that policy change involves use of a presentation or depiction that includes non-guaranteed elements of that policy of life insurance over a period of years, the scale used in the presentation or depiction shall not be greater than the currently payable scale for that block of business. If no presentation or depiction of non-guaranteed elements is used for such policy change, the producer or representative shall certify to that effect in writing on a form provided by the insurer. On the same form, the policyowner shall acknowledge that presentation or depiction was not used."

(b) The text of Section 10(A)(1)(g) shall be deleted, and the following new language shall be inserted in its place:

"The projected termination date of the policy, based on guaranteed assumptions:

For fixed premium policies, this date is when the policy's net cash surrender value is such that it would not maintain the insurance in force, assuming guaranteed interest, mortality and expense loads, and continued scheduled premiums; or

For flexible premium policies, this date is when the policy's net cash surrender value is such that it would not maintain the insurance in force, assuming guaranteed interest, mortality and expense loads, and no further premium payments."

(c) Section 10(A)(1)(h) shall be deleted. (Authorized by K.S.A. 40-103, 40-2401, *et seq.*; implementing K.S.A. 40-103, 40-2401, *et seq.*; effective Dec. 29, 1997; amended Oct. 23, 1998.)

40-2-26. Valuation of life insurance policies. Section one, sections three through seven, and the appendix of the national association of insurance commissioners' "valuation of life insurance policies model regulation," 2003 edition, are hereby adopted by reference, with the following exception: subsection 4A, 4C(1), 4E, and 5F are amended by replacing the bracketed text with the following phrase: "K.S.A. 40-409 and amendments thereto." (Authorized and implementing K.S.A. 40-103 and 40-409; effective Dec. 29, 1997; amended Jan. 1, 2000; amended Feb. 20, 2004.)

40-2-27. Minimum reserve liabilities and nonforfeiture benefits. Sections three through seven of the national association of insurance commissioners' "recognition of the 2001 CSO mortality table for use in determining reserve liabilities and nonforfeiture benefits model regulation," January 2003 edition, are hereby adopted by reference for use in determining the minimum standard of valuation for life insurance policies, with the following exceptions: (a) Subsection 4A is amended by replacing the phrase "January 1, 200[ ]" and the bracketed text that immediately follows with the following phrase: "the effective date of this regulation." Subsection 4A is amended further by replacing the next bracketed text with the following phrase: "K.S.A. 40-409(d)(1)(i) and (iii) and amendments thereto, 40-428(d-3)(8)(F) and amendments thereto, and subsections 5A and 5B of the model regulation adopted by reference in K.A.R. 40-2-26."

(b) Subsection 4B is amended by replacing the bracketed text with the following phrase: "K.S.A. 40-409(d)(i) and (iii) and amendments thereto, 40-428(d-3)(8)(F) and amendments thereto, and subsections 5A and 5B of the model regulation adopted by reference in K.A.R. 40-2-26."

(c) Subsection 5A(2) is amended by replacing the bracketed text and the word "Section" immediately preceding the bracketed text with the following phrase: "K.S.A. 40-409(d)(5) and amendments thereto."

(d) Subsection 5C is amended by replacing the bracketed text with the following phrase: "Subsection 6C of the model regulation adopted by reference in K.A.R. 40-2-26."

(e) Subsection 5D is amended by replacing the first bracketed text and the word "Sections" immediately preceding the bracketed text with the following phrase: "Section 5A of the model regulation adopted by reference in K.A.R. 40-1-44."

(f) The title of Section 6 is amended by replacing the bracketed text with the following phrase: "the valuation of life insurance policies regulation, K.A.R. 40-2-26."

(g) Subsection 6A is amended by replacing each bracketed text with the following phrase: "the valuation of life insurance policies regulation, K.A.R. 40-2-26."

(h) Subsection 7A is amending by replacing the phrase "January 1, 200[ ]" and the bracketed text that immediately follows with the following phrase: "the effective date of this regulation."

(i) Subsection 7C is amended by replacing the bracketed text with the following phrase: "K.S.A. 40-2404 and amendments thereto." (Authorized by K.S.A. 40-103 and 40-409(f); implementing K.S.A. 40-409; effective June 18, 2004.)

40-2-29. Life insurance; valuation of credit life insurance policies. The Kansas insurance department's "policy and procedure regarding determining reserve liabilities for credit life insurance," dated August 23, 2007, including the appendix, is hereby adopted by reference. (Authorized by K.S.A. 40-103 and K.S.A. 2006 Supp. 40-409(f); implementing K.S.A. 2006 Supp. 40-409(d); effective Jan. 18, 2008.)

40-2-30. Military sales practices. The Kansas insurance department's "policy and procedure relating to military sales practices," dated June 26, 2007, is hereby adopted by reference. (Authorized by K.S.A. 40-103 and L. 2007, Ch. 103, Sec. 1; implementing L. 2007, Ch. 103, Sec. 1; effective, T-40-7-26-07, July 26, 2007; effective Oct. 12, 2007.)

Article 3.—FIRE AND CASUALTY INSURANCE

40-3-1. Insurance companies; capital, surplus and deposit requirements. A certificate of authority shall not be issued or renewed with respect to companies writing insurance specified in K.S.A. chapter 40, articles 9, 11, 12 and 16, without compliance with the applicable Kansas capital, surplus, and deposit requirements pertaining to each type of insurance written by the company in any state or country. The company shall comply with the Kansas requirements regardless of the fact the company is not authorized to write each type of insurance in Kansas. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-209, 40-1203, 40-1207, 40-1601, 40-901, 40-1102, 40-1104, 40-1204, 40-1605; effective Jan. 1, 1966; amended May 1, 1986.)

40-3-2. Foreign stock or mutual fire and casualty companies; deposit requirements. Capital stock or mutual fire and casualty insurance companies not organized under the laws of this state shall comply with the deposit requirements contained in articles 9, 10, 11, 12, 15 and 16 of chapter 40, Kansas Statutes Annotated, pertaining to companies organized under the laws of this state. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-209, 40-901, 40-902, 40-1102, 40-1104, 40-1204, 40-1207, 40-1210; effective Jan. 1, 1966; amended Jan. 1, 1970; amended May 1, 1979; amended May 1, 1986.)

40-3-3. (Authorized by K.S.A. 40-103, 40-209, 40-901, 40-902, 40-1102, 40-1104, 40-1204, 40-1207; effective Jan. 1, 1966; revoked May 1, 1979.)

40-3-4. (Authorized by K.S.A. 40-103, 40-216, 40-926, 40-1111, K.S.A. 1978 Supp. 40-928, 40-1113; effective Jan. 1, 1966; revoked May 1, 1979.)

40-3-5. Fire and casualty insurance; rating organizations; filing of forms. For the purpose of this regulation, the word "company" shall include a company of any type that is required to file rates pursuant to K.S.A. 40-955 and amendments thereto. The word "forms" shall mean policies, endorsements, and standard provisions used in policies or endorsements. The term "rating organizations" shall mean any organization licensed pursuant to K.S.A. 40-956 and amendments thereto.

(a) When the constitution, articles of association, bylaws, or regulations of a rating organization grant control over the forms to be used by its member and subscriber companies, the forms shall be filed in compliance with K.S.A. 40-216 and amendments thereto. An individual company shall not be required to file declarations pages or forms that have been filed on its behalf by a rating organization and approved by the commissioner of insurance.

(b) After approval, each member and subscriber of the rating organization making the filings shall adhere to the forms. Each deviation from approved filings shall be deemed to be in violation of K.S.A. 40-216 and amendments thereto, except as provided under K.S.A. 40-958 and amendments thereto.

(c) Except as provided in subsection (a), each company shall be responsible for the following:

(1) Controlling its filings of forms;

(2) promptly discontinuing individual filings of those forms filed on its behalf by a rating organization; and

(3) complying with Kansas individual filings of those forms filed on its behalf by a rating organization. Each company that is not a member of or subscriber to a rating organization shall be required to make an individual filing in accordance with K.S.A. 40-216, and amendments thereto, for each standardized form filed by a rating organization that is accepted by the company.

(d) Each company that becomes a member or subscriber of a rating organization shall be presumed to be issuing the forms of the rating organization from the effective date of membership or subscribership.

(e) Each company that retires from membership or subscribership in a rating organization shall meet the filing requirements by making individual filings. (Authorized by K.S.A. 40-103 and 40-961; implementing K.S.A. 40-216 and 40-955; effective Jan. 1, 1966; amended Jan. 1, 1967; amended May 1, 1979; amended May 1, 1986; amended May 15, 1989; amended May 16, 1997; amended March 10, 2006.)

40-3-6. Fire and casualty insurance; rates and forms; fictitious classification prohibited. (a) No insurer writing Kansas risks shall write fire, casualty, inland marine, or surety coverage upon any firm, corporation, individual, or association of individuals at any preferred rate, coverage, or premium based on any fictitious grouping or classification of risks.

(b) A fictitious grouping or classification of risks shall mean risks that meet the following conditions:

(1) Are inconsistent with the classification or grouping of risks recognized by an insurer's approved rate and policy form filings for individual risks;

(2) do not possess the necessary homogeneous characteristics for group rating and classification; and

(3) do not comply with the provisions of the Kansas insurance code. (Authorized by K.S.A. 40-103, 40-961; implementing K.S.A. 40-953, 40-954; effective Jan. 1, 1966; amended Jan. 1, 1967; amended May 1, 1979; amended May 1, 1986; amended Sept. 3, 2004.)

40-3-7. Fire and casualty insurance; mutual insurers; reciprocal interinsurance exchanges; capital stock insurers issuing participating policies; dividends; requirements. (a) Each fire and casualty insurance contract issued in Kansas by a mutual insurer or reciprocal interinsurance exchange, and each participating fire and casualty insurance contract issued in Kansas by a capital stock insurer, shall contain a provision stating that dividends may be paid on the policy.

(b) A capital stock insurer shall not issue participating policies in Kansas unless:

(1) Issuance authority exists in its charter or articles of incorporation;

(2) The supreme court of its state of domicile has held that a domestic capital stock insurer has inherent authority to issue participating policies; or

(3) The attorney general or chief legal official of its state of domicile has ruled that a domestic capital stock insurer has inherent authority to issue participating policies. (Authorized by K.S.A. 40-103, 40-216; implementing K.S.A. 40-901, 40-1102, 40-1501, 40-1603, 40-1008; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986.)

40-3-8. Fire and casualty insurance; participating policies; filing requirements. Each company writing fire, casualty, inland marine or surety coverages in Kansas on participating policies shall file each participating plan with the insurance department if the plan includes dividend payments on a basis other than the payment of a uniform percentage of the policy premium to all insureds of the company covered by the same policy form. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-941, 40-1122, 40-2404; effective Jan. 1, 1966; amended May 1, 1986.)

40-3-9. Fire and casualty companies; participating policies; payment of dividends to insured required; conditioning dividends on continuance of policy prohibited. (a) Each fire and casualty company issuing participating or dividend-paying policies shall issue dividend checks that are payable to the insured.

(b) Dividends shall not be credited to the account of the agent, except in those cases where the insured has not made payment of all premiums due on the policy under which the dividends are being paid. In such cases, the dividend portion equal to the unpaid premium may be credited to the agent's account, but the company shall retain

evidence substantiating notice to the insured of the dividend amount due and the agent to whom the dividends have been credited.

(c) Each fire and casualty company issuing participating or dividend paying policies shall be prohibited from conditioning the payment of dividends on the continuance of the policy. To prevent unfair discrimination, the dividend shall be payable to the insured regardless of whether the policy is continued or terminated. Crediting of a dividend to the renewal premium shall not be prohibited where the insured desires to renew the policy. When the policy is not continued, the dividend shall be payable in accordance with subsection (a) above. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-941, 40-1122, 40-2404; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986.)

40-3-10. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-941, 40-1122, 40-928, 40-1113, 40-2403; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1981; amended May 1, 1986; revoked Nov. 29, 1993.)

40-3-11. Property insurance; possession of policy in person other than insured; copy for insured. (a) The agent of the insurer shall provide to the insured a certificate or copy of each property insurance policy when:

(1) the property insurance policy is issued to the insured, mortgagee, trustee, or other party having an insurable interest in the involved property; and

(2) the mortgagee, trustee, or other party retains the policy of insurance in his or her possession.

(b) The certificate or copy shall bear complete information as to the type of coverage, the amount of liability, the amount of the premium, and the terms of the contract. (Authorized by K.S.A. 40-103; implementing K.S.A. 16a-4-105; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986.)

40-3-12. Fire and casualty insurance companies; rating plans; requirements. (a) "Individual risk rating plans" shall mean individual risk premium modification plans, schedule rating plans, and similar plans applicable to commercial lines of property and casualty insurance that include one or more of the following types of premium modification:

(1) "Risk modification," which shall mean the application of judgment debits and credits through schedule rating or individual risk premium modification plans to the individual rates otherwise applicable, based on the individual risk's variations in hazard and characteristics of the risk not reflected in the insured's experience. Risk modification shall not include variations in expenses;

(2) "expense modification," which shall mean the variation of the premium for an individual risk that corresponds to the variation in the expenses of this risk from the provision for losses applicable to that entire class of risk; or

(3) "experience modification, excluding retrospective rating plans," which shall mean a variation in the premium for an individual risk that corresponds to that risk's variation in past loss experience from the provision for losses applicable to that entire class of risk.

(b) Individual risk rating plans permitted by K.S.A. 40-954, and amendments thereto, shall meet the following requirements:

(1) Each plan shall specify the kind of insurance or subdivision, or combination, to which the plan applies.

(2) The maximum credit or debit resulting from risk modification shall not exceed 25 percent.

(3) Each plan shall establish standards that bear a relationship to the variation in hazard or expense, or both, to be measured.

(4) Each plan shall be mandatory for all eligible risks and shall be applied by company representatives responsible for underwriting the risk or risks involved in a manner that is uniform and not unfairly discriminatory.

(5) Each company using individual risk rating plans shall obtain all information necessary to determine the proper application of the plans to any particular risk. Each company shall maintain adequate supporting information for examination by the commissioner upon request.

(6) Each change or removal of credits or debits that results from the application of individual risk rating plans shall occur only on the anniversary or renewal of a policy but not during the policy period.

(7) Each change or removal of a debit or credit that was applied under an individual risk rating plan or expense modification shall be based on conclusive evidence that either the conditions that produced the most recent debits or credits no longer exist or their impact has been reduced in direct proportion to the new rating treatment ap-

plied. (Authorized by K.S.A. 40-103 and 40-961; implementing K.S.A. 40-954; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986; amended May 1, 1988; amended March 10, 2006.)

40-3-13. Fire and casualty insurance companies; rating plans; duplication prohibited. Risk modification, as described in K.A.R. 40-3-12, shall not be applied to duplicate factors already fully recognized in the otherwise applicable rate. (Authorized by K.S.A. 40-103 and 40-961; implementing K.S.A. 40-955; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986; amended Sept. 16, 2005.)

40-3-14. Mutual fire and tornado insurance companies; extended coverage endorsement. (a) For the purpose of this regulation, "extended coverage endorsement" means that endorsement insuring the perils of windstorm, hail, explosion, riot, riot attending a strike, civil commotion, aircraft, vehicles, and smoke, except as provided and set out in the extended coverage endorsement prescribed and generally used and in force or hereafter amended and being approved by the insurance commissioner for use by a fire insurance company.

(b) Each Kansas mutual fire and tornado insurance company, organized and operating under article 10 of chapter 40, Kansas Statutes Annotated, and writing the classes of business authorized in K.S.A. 40-1001 only, may issue policies insuring classes of coverage included in the extended coverage endorsement. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-1001; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986.)

40-3-15. Fire and casualty insurance contracts; cancellation at option of insurer; notice required. (a) Each policy or contract, that is issued by fire or casualty insurers within the state of Kansas, and that provides for cancellation at the option of the insurer, shall contain a provision within the policy, or at the discretion of the commissioner, within an amending rider, that the insured will be notified in writing at least 30 days in advance of the effective date of cancellation.

(b) Each fire or casualty insurer that cancels a policy or insurance contract in the state of Kansas, shall provide written notice of cancellation to the insured. Each cancellation notice shall specify the cancellation date and shall state in clear language that the policy is being cancelled. The following statement or one that is substantially the same shall be used: "You are hereby notified that your policy number _____ is cancelled effective _____."

This regulation shall not apply to:

(1) Health, accident or hospitalization policies issued by casualty companies;

(2) crop-hail policies or contracts; or

(3) policies or contracts cancelled as a result of non-payment of premium. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-216, 40-1603(c); effective Jan. 1, 1966; amended Jan. 1, 1968; amended May 1, 1979; amended May 1, 1986.)

40-3-16. Fire and casualty insurance policies and applications; "warranties" prohibited. (a) As used in this regulation, the word "warranty" means a promise that certain facts are truly as they are represented to be and that they will remain so, subject to any specified limitations.

(b) Companies writing fire or casualty insurance, or both, shall not require their Kansas insureds or applicants to make a "warranty," either expressed or implied, of any fact or allegation, either in the application for an insurance policy or in the policy provisions.

(c) The word "representations" or words of similar import shall not be prohibited, nor shall the word "warranty" in an insurance contract be prohibited if the contract contains a definition of "warranty" approved by the commissioner of insurance. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-2404; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986.)

40-3-17. Liability insurance contracts; liability of insuring company. A company shall not issue a liability contract in this state which provides, in effect, that an action may not be maintained against the insuring company unless for recovery of money actually paid by the insured in full satisfaction of a judgment against the insured after trial of the issue. Each liability contract issued in this state shall provide that the insuring company will become liable whenever final judgment is rendered against the insured. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-2404; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986.)

40-3-18. Fire and casualty insurance; private passenger automobiles; rating infor-

mation. Each company writing insurance on private passenger automobiles in Kansas shall include, in all filings submitted to this department, procedures that meet the following conditions:

(a) Obtain from the insured information necessary to permit the company to rate the risk in accordance with applicable filings; and

(b) advise the insured of the proper classification in accordance with the company's applicable rate filings approved by the commissioner. (Authorized by K.S.A. 40-103 and 40-961; implementing K.S.A. 40-216 and 40-955; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986; amended Sept. 16, 2005.)

40-3-19. Fire and casualty insurance; auto physical damage policies; insured's duty to protect property from further loss. The wording, "and any further loss due to the insured's failure to protect, shall not be recoverable under this policy," or wording of similar import, shall be deleted from auto physical damage insurance policy conditions on each policy covering property of the insured. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-216, 40-2404; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986.)

40-3-20. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-216, 5-201 to 5-213, 40-2404, 5-401; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986; revoked May 28, 2004.)

40-3-21. Fire and casualty insurance; medical payments coverage; interpretation. Each insurance company providing "medical payments insurance," pursuant to K.S.A. 40-1110, that affords coverage for reasonable expenses incurred for necessary "funeral services" shall be required to interpret the words "funeral services" in accordance with applicable Kansas law and the terms of the insurance contract. If the words "funeral services" are not specifically interpreted by the contract of insurance or applicable Kansas law, the phrase shall be interpreted to mean:

(a) The opening and closing of a grave; and

(b) a burial plot for one person, if the cost is necessarily incurred after an accident covered by the policy. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-2404; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986.)

40-3-22. Marine, inland marine, and transportation insurance. (a) Risks and coverage that may be classified under Kansas insurance laws as marine, inland marine, or transportation insurance shall be those specified in this regulation. This regulation shall not limit the insuring powers granted under charters and licenses.

(b) Unless otherwise permitted, marine, inland marine, and transportation insurance shall not insure any of the following:

(1) Storage of insured's merchandise, unless specially permitted by this regulation;

(2) merchandise during manufacture that is the property of the manufacturer and is on the manufacturer's premises;

(3) furniture and fixtures, or other improvements to buildings; or

(4) money and securities stored in safes, vaults, and safety deposit vaults at any bank, or on the insured's premises, except while being transported.

(c) Any marine, inland marine, or transportation policy may insure the following:

(1) Imported property wherever located, if the coverage includes risks of transportation. Property shall qualify for coverage as an import if the property maintains its separate identity and has not become mixed with other property in general commerce until one of the following occurs:

(A) The property is sold or delivered by the importer;

(B) the property is taken from its place of storage and put on sale as part of the importer's stock in trade at any sale or distribution point; or

(C) the property is delivered for manufacture, processing, or change in form;

(2) exported property wherever located, if the coverage includes risks of transportation. Property shall qualify for coverage as an export if it meets the following conditions:

(A) Is designated for export or is being prepared for export; and

(B) has not been diverted for domestic trade;

(3) a domestic shipment that begins and ends within the United States, if the coverage includes risks of transportation, including the following:

(A) Property on consignment while it is for sale or distribution; for exhibit, trial, approval, or auction; in transit; in the custody of others; or being returned. Coverage shall not apply to property while on any premises owned, leased, or operated by the consignor;

(B) property that is not on consignment, except under either of the following conditions:

(i) The property is on any manufacturing premises; or

(ii) the property has arrived at any premises owned, leased, or operated by the insured or purchaser;

(4) an instrumentality of transportation or communication, excluding buildings and their improvements, furniture, furnishings, ordinary contents, and stored supplies. Instrumentalities of transportation or communication shall include the following:

(A) Bridges, tunnels, and similar transportation facilities, including their auxiliary structures and equipment;

(B) piers, wharves, docks, slips, dry docks, and marine railways;

(C) pipelines, including on-line propulsion, regulating, and other related appurtenant equipment and excluding property at manufacturing, producing, refining, converting, treating, or conditioning plants;

(D) power transmission lines or telephone and telegraph lines, excluding all property at generating, converting, or transforming stations, substations, and exchanges;

(E) radio and television communication equipment, including towers and antennae with their auxiliary equipment and appurtenant electrical operating and control apparatus; and

(F) outdoor cranes, loading bridges, or similar equipment used for loading, unloading, and transport;

(5) a policy for an individual, including the following:

(A) A personal effects policy;

(B) a personal property policy;

(C) a government service policy;

(D) a personal fur policy;

(E) a personal jewelry policy;

(F) a wedding present policy, for up to 90 days after the wedding day;

(G) a silverware policy;

(H) a fine art policy, insuring paintings, etchings, pictures, tapestries, art glass windows, and other works of art that are rare or that have historical value or artistic merit;

(I) a stamp and coin policy;

(J) a musical instrument policy. "Musical instrument" shall not include a radio, television, or record player, or any combination of these items;

(K) a mobile articles policy covering identified property of a mobile nature common to a household. A floater shall not cover furniture and fixtures that are customarily used on the premises where the property is usually kept;

(L) a machinery and equipment policy, except for policies covering motor vehicles, auto homes, trailers, or semitrailers designed for highway use. Trailers or semitrailers hauled by a tractor not designed for highway use may be covered under this policy, however;

(M) an installment sales and leased property policy covering property, except for motor vehicles designed for highway use, that is in transit and meets either of the following conditions:

(i) Is sold under a conditional contract of sale, partial payment contract, or installment sales contract; or

(ii) is leased. This policy shall not cover beyond the termination of seller's or lessor's interest in the property; or

(N) a live animal policy; or

(6) a commercial property policy for business or professions, including the following:

(A) A radium policy;

(B) a physicians' and surgeons' instrument policy. The policy may also cover furniture, fixtures, and the insured's interest in improvements to buildings located in those portions of the premises occupied by the insured for professional purposes;

(C) a pattern and die policy;

(D) a theatrical policy. However, the policy shall not cover buildings and their improvements and furniture and fixtures that do not travel with theatrical troupes;

(E) a film policy covering either of the following:

(i) A film during production; or

(ii) a completed negative, positive, and sound recording;

(F) a salesmen's samples policy;

(G) an exhibition policy covering property while on exhibition and while in transit to or from an exhibition;

(H) a live animal policy;

(I) a builders' risk or installation risk policy, covering machinery, equipment, building materials, or supplies being used with and during installation, testing, building, renovating, or repairing. A policy may cover property designated for and awaiting specific installation, building, renovating, or repairing under any of the following conditions:

(i) While at a point or place where work is being performed;

(ii) while in transit; or

(iii) during temporary storage or deposit. The

policy shall cover against perils in addition to fire and extended coverage perils. Coverage shall cease when an insured owner completes and accepts the building or installation and the insured seller's or contractor's interest ceases;

(J) a mobile articles policy covering identified property of a mobile nature that is in the custody or control of a party who intends to use the property for its manufactured or created purpose. The policy shall not cover furniture and fixtures that are not customarily used away from the premises where the property is usually kept;

(K) a machinery and equipment policy, except for a motor vehicle or snow plow designed for highway use, an auto home, or a trailer or semitrailer unless hauled by a tractor not designed for highway use;

(L) a bailment policy covering property in the custody of any bailee and while in transit to or from the bailee. Any bailment policy may include coverage that will indemnify the owner of the property for loss from specific perils subject to approval by the commissioner of insurance pursuant to K.S.A. 40-216(a) and amendments thereto. The application of an additional or separate charge for the indemnity coverage shall not constitute the transaction of the business of insurance if the charge does not exceed the premium approved by the commissioner and the bailee and if the bailee's employees or other organizations receive no compensation or other valuable consideration for performing the administrative tasks associated with the insurance coverage. The policy shall not insure property if either of the following conditions is met:

(i) The property is owned by the bailee at the bailee's premises; or

(ii) the property is in the custody of any bailee owned, controlled, or operated by the bailor;

(M) an installment sales and leased property policy covering property, except a motor vehicle designed for highway use, that is in transit and meets either of the following conditions:

(i) Is sold under a conditional contract of sale, partial payment contract, or installment sales contract; or

(ii) is leased. The policy shall not cover any point beyond the termination of the seller's or lessor's interest in the property and shall not cover machinery and equipment subject to certain "lease-back" contracts. A "lease-back" contract shall mean a contract, expressed or implied, under which the property is purchased by the lessor for the benefit and use of the lessor. This provision shall not apply to "lease-back" contracts involving machinery and equipment for which marine or inland marine coverage is otherwise permitted by this definition while the machinery and equipment are in the custody of the lessee;

(N) a garment contractors policy;

(O) a furrier or fur storer policy covering specified articles belonging to a customer for which the furrier or fur storer issues a certificate or receipt to the customer;

(P) an accounts receivable policy and valuable papers and records policy;

(Q) a floor plan policy covering property for sale, except for an automobile or other motor vehicle designed for highway use, while in transit and while in possession of any dealer under a plan by which the dealer borrows money from a bank or lending institution with which to pay the manufacturer. In addition, the following requirements shall be met:

(i) The property shall be specifically identifiable as encumbered to the bank or lending institution;

(ii) the dealer's right to sell or otherwise dispose of the property shall be conditioned upon its being released from encumbrance by the bank or lending institution; and

(iii) the policy shall not cover any point beyond the termination of the dealer's interest in the property;

(R) a sign and street clock policy. The policy may include insurance of a neon sign, an automatic or mechanical sign, and a street clock while in use;

(S) a fine art policy for the account of a museum, gallery, university, business, municipality, or other similar interest, covering paintings, etchings, pictures, tapestries, art glass windows, and other works of art that are rare or have historical value or artistic merit;

(T) a dealers policy insuring a dealer in personal property that may be covered specifically under an inland marine policy by the ultimate purchaser. A policy under this paragraph may cover money stored in locked safes or vaults on the insured's premises, furniture, fixtures, tools, machinery, patterns, molds, dies, and the insured's interest as a tenant in improvements to buildings. This policy may include the following:

(i) Any musical instrument dealer covering property consisting principally of musical instruments and their accessories. Musical instruments

shall not include radios, televisions, record players, and any combinations of these items;

(ii) any camera dealer covering property consisting principally of cameras and their accessories;

(iii) any fur dealer covering property consisting principally of furs and fur garments;

(iv) any equipment dealer covering mobile agricultural and construction equipment and accessories, except for motor vehicles designed for highway use;

(v) any stamp or coin dealer covering property of a philatelic or numismatic nature;

(vi) any jeweler's block; and

(vii) any fine art dealer;

(U) a woolgrower's policy;

(V) a domestic bulk liquid policy, covering tanks and domestic bulk liquids stored in them;

(W) a difference-in-conditions policy. The policy shall not insure against fire and extended coverage perils; and

(X) any electronic data processing policy. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-901; effective Jan. 1, 1966; amended Jan. 1, 1967; amended May 1, 1986; amended Jan. 6, 1992; amended March 17, 2006.)

40-3-23. Fire and casualty insurance except accident and health; binder forms required to be filed. Binders or other temporary contracts of insurance are subject to K.S.A. 40-216. These forms shall be filed with and approved by the commissioner in accordance with applicable statutory provisions. (Authorized by K.S.A. 40-103, 40-216; implementing K.S.A. 40-216; effective Jan. 1, 1967; amended May 1, 1986.)

40-3-24. Fire and casualty insurance; inland marine rules, rates, and rating plans; general custom of industry defined. (a) The following types of risks shall be the inland marine classes that are, by general custom of the industry, written according to manual rates or rating plans:

(1) Bicycle floater;

(2) cameras;

(3) fine art in private collections;

(4) golfer's equipment floater;

(5) musical instruments;

(6) personal articles floater;

(7) personal effects;

(8) personal furs or fur floater;

(9) personal jewelry or jewelry floater;

(10) personal property floater;

(11) silverware floater;

(12) stamp and coin collection floater;

(13) tourist baggage;

(14) travel baggage, if issued in combination with accident and sickness insurance; and

(15) wedding presents.

(b) Inland marine rates required for filing pursuant to K.A.R. 40-1-19 shall not be subject to this regulation. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-955; effective Jan. 1, 1967; amended May 1, 1979; amended May 1, 1986; amended Sept. 16, 2005.)

40-3-25. Same; writing of risks rated differently from normal market; requirements. (a) As used in this regulation, "normal market" shall mean insurance companies that sell policies to preferred or standard risks. Preferred or standard risks are applicants or policyholders who qualify for coverage at favorable premiums due to their underwriting characteristics.

(b) Each company issuing a fire and casualty insurance policy in this state with a premium rate that results from the insured's inability to obtain coverage in the normal market shall include a statement on the application or policy form, signed by the applicant or named insured, that contains the following statements, as applicable, or statements with similar wording:

(1) "I am unable to obtain _____ (state kind) insurance at normal rates and hereby request the issuance of this policy at rates in excess of normal rates."

(2) "I have been unable to procure similar insurance at normal rates although my risk has been submitted to at least three other insurance companies authorized to transact insurance business in Kansas."

(3) For automobile liability insurance, the statements in the following paragraphs shall be included:

(A) "(1) I have been unable to procure similar insurance at normal rates, or (2) I have been unable to procure similar insurance at normal rates because my previous insurance company nonrenewed or canceled my insurance."

(B) "I understand that liability limits sufficient to meet the financial responsibility requirements of the state may be available through the Kansas automobile insurance plan." The preceding statement shall not apply if the policy is issued through the Kansas automobile insurance plan.

(4) For workers compensation and employers liability insurance, the following statement shall

be included: "I understand that I may obtain workers compensation and employers liability insurance through the Kansas workers compensation insurance plan." The preceding statement shall not apply if the policy is issued through the Kansas workers compensation insurance plan.

(5) For fire and extended coverage insurance, the following statement shall be included: "I understand that I may be able to obtain adequate fire and extended coverage insurance through the Kansas all-industry placement facility." The preceding statement shall not apply if the policy is issued through the Kansas all-industry placement facility.

(6) For a health care provider required to comply with K.S.A. 40-3402 and amendments thereto, the following statement shall be included: "I understand that I may be able to obtain adequate basic professional liability coverage through the Kansas health care provider insurance availability plan." The preceding statement shall not apply if the policy is issued through the Kansas health care provider insurance availability plan. (Authorized by K.S.A. 40-103, 40-961(d), 40-2116, and 40-3417; implementing K.S.A. 40-954(d), 40-2,124, 40-2102, 40-2109, and 40-3413; effective Jan. 1, 1967; amended Jan. 1, 1970; amended May 1, 1986; amended Jan. 18, 2008.)

40-3-26. Modification of rate filing requirements for individual risks. Rates modified for individual risks pursuant to K.S.A. 40-954(d) and amendments thereto shall be retained in the insurer's underwriting file for five years after the rate is no longer applicable to the insured. These rates shall be made available upon the request of the commissioner. These rate filings shall otherwise comply with the applicable provisions set forth in K.S.A. 40-954 and 40-955 and amendments thereto, and K.A.R. 40-3-25. (Authorized by K.S.A. 40-103; implementing K.S.A. 1998 Supp. 40-954, 40-955, as amended by L. 1999, Ch. 63, § 2; effective, E-76-19, May 1, 1975; effective May 1, 1976; amended May 1, 1979; amended May 1, 1986; amended May 16, 1997; amended March 24, 2000.)

40-3-27. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-1113a, 40-928(g); effective Jan. 1, 1968; amended May 1, 1979; amended May 1, 1986; amended May 16, 1997; revoked May 19, 2000.)

40-3-28. Fire and casualty insurance; automobile liability policies; limits of liability. When an insurance company effects a unilateral reduction in the limits of liability contained in a policy of automobile liability insurance as defined in K.S.A. 40-276, the action shall be deemed a cancellation of the policy and shall be subject to the provisions of K.S.A. 40-276, 40-277, 40-278, 40-279, and 40-280. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-276, 40-277; effective Jan. 1, 1968; amended May 1, 1979; amended May 1, 1986.)

40-3-29. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-281; effective Jan. 1, 1968; amended May 1, 1986; revoked June 22, 2001.)

40-3-30. Fire and casualty insurance; assigned risk plans; forms and procedures. Each insurance company authorized to transact fire and casualty business in this state shall inform its certified agents of the Kansas assigned risk plans, their availability, eligibility and other related procedures. Insurance companies shall also require each agent to maintain an adequate supply of forms necessary to place risks in the various Kansas-assigned risk plans. This regulation shall apply only with respect to agents certified to write insurance for which a Kansas assigned risk plan is available. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-278, 40-2109, 40-2102; effective Jan. 1, 1969; amended May 1, 1979; amended May 1, 1986.)

40-3-31. Fire and casualty insurance; automobile liability policies; notices of cancellation or nonrenewal; requirements. (a) Each company writing a private passenger automobile liability policy, with the exception of a policy written through the Kansas automobile insurance plan, shall include, in filings submitted to this department, all forms designed to give direct notice of cancellation or nonrenewal to an insured. Filings may be made either independently or through a licensed rating organization with which the insurer is affiliated.

(b) The notice of cancellation or nonrenewal, or accompanying forms, shall include words similar to the following statements:

(1) Within 10 days after receiving a written request, this company will furnish, the reason for the cancellation or nonrenewal in writing. This statement is required only when reasons for cancellation or nonrenewal are not sent with the cancellation or nonrenewal notice.

(2) (When cancellation or nonrenewal is for any reason other than nonpayment of premium.) The provisions of K.S.A. 40-278 require that you be advised that liability limits sufficient to meet the financial responsibility requirements of the state may be available through the Kansas automobile insurance plan. Each agent writing automobile liability insurance for this company has been informed, and must be able to assist, in the preparation of the necessary forms for the Kansas automobile insurance plan. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-276a, 40-277, 40-278; effective Jan. 1, 1968; amended, E-72-20, July 17, 1972; amended Jan. 1, 1973; amended May 1, 1979; amended May 1, 1986.)

40-3-32. Fire and casualty insurance; modification of form filing requirements. (a) Bond forms. Bonds that cannot practicably be filed before they are used shall not be required to be filed with the commissioner if they are required by any of the following:

(1) Law;

(2) court order; or

(3) any federal, state, or municipal government or agency.

(b) Marine or inland marine forms. Each marine or inland marine form that cannot practicably be filed before use shall not be required to be submitted for approval pursuant to K.S.A. 40-216 and amendments thereto. This exception shall not apply to marine or inland marine policy and endorsement forms that contain standardized wording.

(c) Aircraft hull or aircraft liability endorsement forms. Each aircraft hull or aircraft liability endorsement form that cannot practicably be filed before use shall not be required to be submitted for approval pursuant to K.S.A. 40-216 and amendments thereto. This subsection shall not apply to aircraft hull or aircraft liability endorsement forms that contain standardized wording or that are so designated by the commissioner. Basic aircraft hull or aircraft liability insurance policies shall be subject to the filing requirement of K.S.A. 40-216 and amendments thereto.

(d) Restrictive endorsements. Each fire and casualty endorsement or form used on an individual risk that restricts coverage otherwise applicable, shall be considered an increase in the rate otherwise applicable and considered as forms that cannot practicably be filed before they are used. These forms shall be retained in the insurer's underwriting file for a period of five years after the form is no longer applicable to the insured. These forms shall be made available for review upon the request of the commissioner. The disapproval of any form shall be effective as of the inception date of the policy to which it is attached and shall be deleted from the policy.

(e) Policy or endorsement form prescribed by committee on surety bonds and insurance. Each property and casualty policy or endorsement form specifically prescribed by the committee on surety bonds and insurance pursuant to K.S.A. 75-4109, and amendments thereto, shall need not be required to be filed with the commissioner of insurance. The phrase "forms specifically prescribed by the committee on surety bonds and insurance" shall mean each property and liability policy, endorsement, or amendment, the exact wording for which is contained in an invitation for bids authorized by the committee.

(f) Each form submitted pursuant to this regulation shall be deemed approved unless disapproved by the commissioner within 30 days of receipt. (Authorized by K.S.A. 40-103, 40-216, as amended by L. 1999, Ch. 63, § 1; implementing K.S.A. 40-216, as amended by L. 1999, Ch. 63, § 1; effective Jan. 1, 1968; amended Jan. 1, 1973; amended Jan. 1, 1974; amended May 1, 1975; amended May 1, 1979; amended May 1, 1986; amended Nov. 29, 1993; amended March 24, 2000.)

40-3-33. Fire and casualty insurance; basic property insurance; inspection; placement; procedures; requirements. (a) Each insurer, as defined in this program, shall file a statement with the commissioner, pledging its full participation and cooperation in carrying out the program established by this regulation.

(b) Definitions.

(1) "All-industry placement facility" or "facility" means the organization formed by insurers to assist applicants in securing basic property and casualty insurance and to administer the fair access to insurance requirements (FAIR) plan and the joint reinsurance association.

(2) "Basic property insurance" means the coverage for eligible risks against direct loss to real and tangible personal property at a fixed location that is provided in a basic fire policy including builder's risk. Extended coverage perils, including vandalism and theft insurance, may also be added at the discretion of the governing committee. Ba-

sic property insurance shall not include farm risks, automobile risks, types of manufacturing risks, or other risks excluded by the governing committee with the approval of the commissioner.

(3) "Casualty insurance" means the coverage for eligible risks for covered losses because of bodily injury or property damage or medical payments to others as a result of an accident caused by an occurrence to which coverage applies as approved by the governing committee with the approval of the commissioner. Casualty shall not include automobile, workers compensation, health, fidelity, surety, boiler and machinery, credit, aircraft, or other kinds of casualty insurance excluded by the governing committee with the approval of the commissioner.

(4) "Commercial" means basic property insurance included under the commercial lines statistical record other than automobile.

(5) "Commissioner" means the commissioner of insurance of the state of Kansas.

(6) "Fire division" means a building or structure eligible for separate rating in accordance with the rules filed with the commissioner by a licensed rating organization.

(7) "Habitational" means basic property and casualty insurance included under the personal lines statistical record other than automobile.

(8) "Inspection bureau" means the rating bureau or other organization designated by the facility with the approval of the commissioner to make inspections as required under the program and to perform other duties authorized by the facility.

(9) "Insurer" means any insurance company or other organization licensed to write and engaged in writing property or casualty insurance business in this state on a direct basis, including the property insurance components of multi-peril policies. This definition shall not include insurers who elect not to participate.

(10) "Joint reinsurance association" means the association formed by the insurers that provides for the equitable distribution of risks.

(11) "Person" includes any individual or group of individuals, corporation, partnership, association, or any other organized group of persons.

(12) "Premiums written" means gross direct premiums, excluding that portion of premium on risks ceded to the joint reinsurance association, charged during the second preceding calendar year with respect to property in this state on all policies of basic property and casualty insurance, and the basic property and casualty premium components of all multi-peril policies, as computed by the facility, less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits.

(13) "Program" means the system of providing insurance coverage through the all-industry placement facility and joint reinsurance association.

(14) "Property owner," with respect to any real, personal, or mixed real and personal property, means any person having an insurable interest in the property.

(15) "Servicing insurer" means an insurer designated by the governing committee to issue policies on behalf of the facility.

(c) The manner and scope of the inspections of facility business shall be prescribed by the facility with the approval of the commissioner.

(d) An inspection report shall be made for each risk inspected. The report shall cover pertinent structural and occupancy features as well as the general condition of the building, its premises, and surrounding structures. Representative photographs of the property may be taken during the inspection.

(e) Within 12 business days after the inspection, a copy of the completed inspection report and any photographs shall be sent promptly to the facility. A copy of the inspection report shall be made available to the applicant.

(f) If, upon receipt of an application for coverage, the facility finds that the risk is eligible for insurance under the program, the facility shall assign the risk to the servicing insurer.

(g) After assignment of a risk to the servicing insurer, the facility shall apportion the liability so assumed to the insurers in the manner provided in this program.

(h) Assessments upon each insurer in the program for expenses in connection with facility business shall be levied and assessed by the governing committee of the facility in the manner provided in this program, subject to any minimum assessment that may be established by the governing committee.

(i) All servicing expenses of the servicing insurer shall be recoverable from the facility in the manner and to the extent determined by the governing committee.

(j) The maximum limits of liability that may be placed through the program shall be as follows:

(1) On any habitational property in one fire di-

vision under one ownership, its insurable market value, actual cash value, or $200,000, whichever is less. This limit of liability shall apply jointly to real and personal property. In addition, the program may offer a maximum of $10,000 theft coverage on personal property, and $100,000 liability coverage with an aggregate limit of $200,000, and $1,000 medical payments; and

(2) on any commercial property in one fire division under one ownership, its insurable market value, actual cash value, or $1,000,000, whichever is less. Maximum limits shall apply jointly to real and personal property.

(k) The facility shall, within 10 business days after receipt of all required documentation, advise the applicant of one of the following:

(1) The risk is acceptable.

(2) The risk is acceptable at a surcharged rate, and the facility shall advise the applicant of any specific conditions and charges.

(3) The risk is declined but will be acceptable if the actions or improvements noted in the declination notice are made by the applicant and acknowledged by the facility.

(4) The risk is not eligible for the reasons stated in the declination notice.

(l) If a risk is declined because it fails to meet reasonable underwriting standards, the facility shall so notify the applicant. Factors to be considered when assessing whether or not a risk meets reasonable underwriting standards shall include the following:

(1) The physical condition of the property, including its construction, heating, wiring, evidence of previous fires, or general deterioration;

(2) its present use or housekeeping;

(3) any other exposure determined by the governing committee and approved by the commissioner; or

(4) any combination of (l)(1), (2), and (3).

(m) If the risk is acceptable to the facility, the facility shall notify the applicant and the licensed producer designated by the applicant, of the name of the servicing insurer and the premium to be charged. Upon receipt of adequate premium, a policy shall be issued within five business days.

(n) In the event that all or part of the risk is conditionally declined because the risk does not meet reasonable underwriting standards but can be improved to meet the standards, the facility shall promptly advise the applicant of what actions or improvements noted in the declination notice should be made. Upon satisfactory completion of the improvements and notification to the facility, the facility may have the property reinspected and shall then process the application in the manner described in this program.

(o) If the inspection of the risk reveals that there are one or more substandard conditions, surcharges may be imposed in conformity with the filings approved by the commissioner.

(p) If the facility declines all or part of the risk, the facility shall promptly send a declination notice to the applicant. At the time the facility sends this notice to the applicant, it shall also advise the applicant of the right to appeal the decision of the facility to the commissioner and shall set forth in writing the procedures to be followed for the appeal.

(q) Any insurer who is a member of a group of insurers under the same management or ownership shall have the option of designating the insurer within the group to whom assignments shall be made as a servicing insurer.

(r) The servicing insurer shall cede to and the joint reinsurance association shall assume 100 percent of all policies written under the program.

(s) A joint reinsurance association shall be created consisting of all insurers who elect to participate.

(t) Each insurer shall participate in the writings, expenses, profits, and losses of the association in the following manner:

(1) For habitational risks, in the same proportion as its habitational premiums written bear to the aggregate habitational premiums written by all insurers in the program; and

(2) for commercial risks, in the same proportion as its commercial premiums written bear to the aggregate commercial premiums written by all insurers in the program.

(u) The association shall adopt a plan of operation and rules of procedure that, before being placed into effect, shall be filed with and approved by the commissioner. Any amendments to the plan of operation or rules of procedure so adopted shall also be filed and approved by the commissioner before being placed into effect.

(v) All policies shall be issued on the forms and in accordance with the rates and rating procedures approved by the commissioner for use with the program. The policies shall be issued for a term of one year.

(w) The servicing insurer shall not cancel a policy issued under the program without approval of the facility.

(x) A notice of cancellation of a policy issued under the plan, together with a statement of the reason for it, shall be sent no fewer than 30 days before the cancellation date. However, in cases of nonpayment of premium, the cancellation notice shall be sent no fewer than 10 days before the cancellation date. Any declination at expiration of a policy shall be sent no fewer than 30 days before expiration for habitational risks and no fewer than 60 days before expiration for commercial risks.

(y) Each notice of cancellation or declination at expiration sent to the insured relating to a policy issued under the program shall contain the procedures for reconsideration by the facility and shall be accompanied by a statement that the insured has a right of appeal.

(z) Any applicant may make a written appeal of a decision of the facility relating to the conditions for acceptance of coverage. This appeal shall be made to the commissioner within 30 days from the decision of the facility.

(aa) Other than as provided elsewhere in the program, any applicant or insurer shall have the right of appeal to the governing committee. A decision of the committee may be appealed in writing to the commissioner within 30 days from the action or decision of the committee.

(bb) Commissions under the program shall be as determined by the governing committee and shall be paid to the licensed producer designated by the applicant. The facility shall pay the applicable commission to an agent licensed to write property and casualty insurance in the state of Kansas.

(cc) This program shall be administered by a governing committee of the facility, subject to the supervision of the commissioner, and operated by a manager appointed by the committee.

(dd) The governing committee shall have the authority to make and issue the operating rules necessary to implement this program. The operating rules shall be subject to approval by the commissioner before their use.

(ee) The governing committee shall consist of seven insurers and two agents, who shall be selected from each of the following:

(1) Kansas association of property and casualty companies;

(2) other non-stock companies;

(3) other stock companies;

(4) Kansas stock insurers;

(5) alliance of American insurers;

(6) American insurance association;

(7) national association of independent insurers; and

(8) Kansas association of insurance agents.

The three insurer associations shall designate their representatives to the committee. The two Kansas insurer groups shall designate their representatives in the manner mutually agreed upon by their respective companies. The agents' association shall designate its representatives to the committee. The "other stock companies" and "other non-stock companies" members of the committee shall be selected by the other seven representatives.

(ff) Representatives on the governing committee shall serve for a period of one year or until successors are elected or designated.

(gg) There shall be an annual meeting of the insurers and members of the governing committee on a date fixed by the committee.

(hh) A special meeting may be called at a time and place designated by the committee or upon the written request to the committee by 10 insurers, not more than one of which may be in a group under the same management or ownership.

(ii) Twenty days' written notice of the annual or special meeting shall be given by the committee to the insurers. A majority of the insurers shall constitute a quorum. Voting by proxy shall be permitted. Notice of any meeting shall be accompanied by an agenda for the meeting.

(jj) Any matter, including amendment of this program, may be proposed and voted upon by mail if this procedure is unanimously authorized by the members of the governing committee. If so approved by the committee, notice of any proposal shall be mailed to the insurers no fewer than 20 days before the final date fixed by the committee for voting on it.

(kk) At any regular or special meeting at which the vote of the insurers is or may be required on any proposal including amendment to this program, or any vote of the insurers that may be taken by mail on any proposal, the votes shall be cast and counted on a weighted basis in accordance with each insurer's premiums written. On any proposal deemed by the governing committee to relate exclusively to habitational or exclusively to commercial business, the votes shall be cast and counted on a weighted basis in accordance with each insurer's respective habitational or commercial premiums written. A proposal shall become effective when approved by at least two-thirds of the votes cast on this weighted basis.

(ll) Each amendment of the program shall be subject to approval by the commissioner.

(mm) The committee shall meet as often as may be required to perform the general duties of administration of the facility or on the call of the commissioner.

(nn) The governing committee shall be empowered to appoint a manager, who shall serve at the pleasure of the committee, to budget expenses, levy assessments, disburse funds, and perform all other duties necessary or incidental to the proper administration of the facility.

(oo) Annually, the manager shall prepare an operating budget that shall be subject to approval of the governing committee. This budget shall be furnished to the insurers after approval.

(pp) The governing committee shall furnish to all insurers and to the commissioner an annual written report of operations. The form and detail of the report shall be determined by the committee.

(qq) The presence of seven members of the governing committee, at least five of whom shall be insurers, shall constitute a quorum.

(rr) The governing committee shall appoint any committees that it may deem advisable.

(ss) The servicing insurer shall maintain records by policyholder, producer of record, and dates of coverage for each application received and maintain any other records that may be required by the governing committee or the commissioner.

(tt) The servicing insurer shall separately code and maintain separate statistics on business written in accordance with the foregoing program and shall make reports thereon as may be required by the governing committee or the commissioner.

(uu) The manager shall submit annually, or at any other periods that may be designated by the commissioner, to the governing committee and the commissioner a report setting forth the number of new applications received, renewal policies paid, the number of risks inspected, the number of policies issued, and any other information that the commissioner may request. (Authorized by K.S.A. 40-103, 40-2116; implementing K.S.A. 40-2101; effective, E-69-3, Oct. 7, 1968; amended, E-69-5, Jan. 8, 1969; effective Jan. 1, 1970; amended, E-70-41, Sept. 1, 1970; amended Jan. 1, 1970; amended May 1, 1988; amended Nov. 29, 1993; amended July 30, 1999.)

40-3-34. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-295, 40-296, 40-297; effective, E-71-29, July 16, 1971; effective Jan. 1, 1972; amended May 1, 1979; amended May 1, 1986; revoked Sept. 28, 2007.)

40-3-35. Fire and casualty insurance; Kansas automobile injury reparations act; Kansas automobile assigned claims plan; requirements; review of plan; approval; disapproval; procedure; amendments. (a) The Kansas automobile assigned claims plan shall consist of every insurer and self-insurer authorized to write motor vehicle liability insurance in this state. Each authorized insurer and self-insurer shall, in accordance with K.S.A. 1988 Supp. 40-3116, cooperate in preparing and submitting to the commissioner of insurance a plan or plans for the assignment of applicants for certain motor vehicle personal injury protection claims for certain persons injured in automobile accidents in Kansas. The plan or plans shall provide:

(1) Reasonable rules governing the operating procedures of the Kansas automobile assigned claims plan, including:

(A) The designation of servicing insurers;

(B) the distribution of claims to servicing insurers; and

(C) adequate provision for the equitable payment of assigned claims;

(2) a method providing applicants for personal injury protection benefits and insurers with a hearing on grievances and the right of appeal to the commissioner; and

(3) for the establishment of procedures regarding records to be kept of all financial transactions of the Kansas automobile assigned claims plan and the submission of an annual financial report to the commissioner of insurance.

(b) Each plan shall be subject to the approval of the commissioner and may be disapproved if it fails to meet the requirements set forth in paragraphs (1), (2), and (3) of subsection (a).

(c) A submitted plan that does not meet the standards set forth in paragraphs (1), (2), and (3) above shall be, after a hearing, revised to meet the requirements. If after a hearing, the commissioner finds that an activity or practice of an insurer or rating organization in connection with the operation of the plan or plans is unfair or unreasonable or otherwise inconsistent with the provisions of this regulation, the commissioner may issue a written order specifically identifying the unfair, unreasonable, or inconsistent activity or

practice, and may require discontinuance of the activity or practice.

(d) For each plan or plans, a governing committee shall be appointed by the commissioner of insurance. The committee shall meet at least once annually to review and prescribe operating rules.

(e) The committee shall consist of nine members who shall be appointed as follows:

(1) Three members shall be representatives of foreign insurance companies.

(2) Two members shall be representatives of domestic insurance companies.

(3) Two members shall be licensed independent insurance agents.

(4) Two members shall be representative of the general public interest.

(f) Each member shall be appointed for a term specified by the commissioner. (Authorized by K.S.A. 40-103, 40-3119, K.S.A. 1988 Supp. 40-3116(d); implementing K.S.A. 1988 Supp. 40-3116; effective, E-74-8, Jan. 1, 1974; effective May 1, 1975; amended May 1, 1976; amended May 1, 1979; amended May 1, 1986; amended April 16, 1990.)

40-3-36. Same; Kansas automobile injury reparations act; motor vehicle liability insurance policy defined. For the purpose of compliance with K.S.A. 40-3118a, "policy of motor vehicle liability insurance" shall mean a contract meeting the requirements of K.S.A. 40-3104, issued by an insurer defined in K.S.A. 40-3103(g), at the date of issuance and inception date of the contract. (Authorized by K.S.A. 40-103, 40-3119; implementing K.S.A. 40-3118; effective, E-76-19, May 1, 1975; effective May 1, 1976; amended May 1, 1986.)

40-3-37. Fire and casualty insurance; cancellation of automobile liability insurance policies; premium finance plan defined. The reference to "premium finance plan" contained in K.S.A. 40-277 shall mean a premium financing plan as defined in K.A.R. 40-1-10, an installment payment plan recognized by the insurer's existing rule and rate filings, or the extension of credit to an automobile liability insurance policyholder by an insurance agent as permitted by K.S.A. 40-282. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-277; effective May 1, 1976; amended May 1, 1979; amended May 1, 1986.)

40-3-38. Mortgage guaranty insurance; unearned premium reserves. Each mortgage guaranty insurance company, defined by K.S.A. 40-3502(a), shall compute and maintain an unearned premium reserve in an amount not less than the unearned premium or reserves required by the provisions of K.S.A. 40-234. (Authorized by K.S.A. 40-103, 40-3521; implementing K.S.A. 40-3516; effective, E-79-3, Jan. 19, 1978; effective May 1, 1979; amended May 1, 1981; amended May 1, 1986.)

40-3-39. Fire and casualty insurance; crediting against future personal injury protection benefits; terms defined. The phrase "the amount of such judgment, settlement, or recovery," as contained in and applied to, the second sentence of K.S.A. 40-3113a(b), means amounts which are duplicative of payable personal injury protection benefits. (Authorized by K.S.A. 40-103, 40-3119; implementing K.S.A. 40-3113a; effective, E-78-24, Sept. 7, 1977; effective May 1, 1979; amended May 1, 1986.)

40-3-40. Fire and casualty insurance; unfair rate discrimination; certain acts and practices included. (a) Unfair rate discrimination practices between individuals of the same rating class, as prohibited by K.S.A. 40-953 and amendments thereto, shall include the following:

(1) Refusing to insure;

(2) refusing to continue to insure;

(3) limiting the amount, extent, or kind of coverage available to an individual; and

(4) charging an individual a different rate for the same coverage solely because of the geographic location of the risk.

(b) When an act or practice is permitted by rate filings in accordance with K.S.A. 40-955 and amendments thereto, the provisions of subsection (a) shall not apply. (Authorized by K.S.A. 40-103 and 40-961; implementing K.S.A. 40-953; effective May 1, 1979; amended May 1, 1986; amended March 17, 2006.)

40-3-41. Fire and casualty insurance; automobile business defined; application of automobile business liability insurance. (a) The term "automobile business" contained in K.S.A. 40-3107(h)(2) shall mean a business which sells, leases, repairs, services, transports, stores, or parks motor vehicles designed primarily for use on public highways. The definition shall include road testing and delivery.

(b) Each motor vehicle liability insurance coverage provided pursuant to K.S.A. 40-3107 shall

be primary, duplicative, participative, or excess over any liability insurance coverage available from an automobile business. (Authorized by K.S.A. 40-103, 40-3119; implementing K.S.A. 40-3107; effective May 1, 1982; amended May 1, 1986.)

40-3-42. Title insurance; unfair inducements; prohibited acts. (a) As used in this regulation:

(1) "Title entity" means a title insurance company, title insurance agent, title insurance agency or any other organization directly involved in the sale, underwriting, or servicing of title insurance.

(2) "Producer of title business" means any natural person, firm, association, organization, partnership, business trust, corporation, or other legal entity engaged in this state in the trade, business, occupation, or profession of:

(A) buying or selling interests in real property;

(B) making loans secured by interests in real property; or

(C) acting as broker, agent, representative, or attorney of natural persons or other legal entities that buy or sell interests in real property or that lend money with such interests as security.

(b) The following acts constitute rebates or unlawful inducements in the marketing of title insurance on property located in this state:

(1) The disbursement, on behalf of a customer or prospective customer, of funds prior to the actual deposit thereof with the escrow or closing agent;

(2) disbursement of escrow funds before the conditions of the escrow have been met;

(3) making a charge for any title commitment which does not have a reasonable relation to the cost of production of the commitment or is less than the minimum fee or charge for the type of policy applied for, as set forth in the agent's filed schedule of fees and charges. This provision does not apply where a title commitment is furnished in good faith in furtherance of a bona fide sale, purchase or loan transaction which for good reason is not consummated;

(4) paying a producer of title business to make an inspection of property;

(5) any transaction in which any person receives, or is to receive, securities of the title entity at prices below the normal market price, or bonds or debentures which guarantee a higher than normal interest rate, whether or not the consummation of the transaction is directly or indirectly related to the number of escrows or title orders coming to the title entity through the efforts of such person;

(6) charging a subdivision discount rate which is not applicable in the particular transaction because the volume required to qualify for the discount includes ineligible lots or parcels;

(7) paying for, or offering to pay for, the cancellation fee, the fee for the preliminary title report or other fee on behalf of any producer of title business before or after inducing such producer of title business to cancel an order with another title entity;

(8) giving, receiving or guaranteeing, or offering to give, receive or guarantee, either directly or indirectly, any loan with any producer of title business, regardless of the terms of the note or guarantee;

(9) guaranteeing, or offering to guarantee, the performance of escrow services or any other undertaking by any producer of title business;

(10) providing, or offering to provide, either directly or indirectly, a "compensating balance" or deposit in a lending institution either for the express or implied purpose of influencing the extension of credit by such lending institution to any producer of title business, or for the express or implied purpose of influencing the placement or channeling of title insurance business by such lending institution;

(11) paying for, or offering to pay for, the fees or charges of an outside professional including but not limited to an attorney, engineer, appraiser, or surveyor whose services are required by any producer of title business to structure or complete a particular transaction;

(12) providing, or offering to provide, without reasonable charge non-title services including but not limited to escrow services, computerized bookkeeping, forms management, computer programming, or any similar benefit to any producer of title business;

(13) furnishing, or offering to furnish, without reasonable charge all or any part of the time or productive effort of any employee of the title entity including but not limited to office manager, escrow officer, secretary, clerk or messenger to any producer of title business. However, messenger service normally provided by a title entity in the ordinary course of its title insurance business shall not constitute a violation of this provision;

(14) paying for, or offering to pay for, all or any

part of the salary of an employee of any producer of title business;

(15) paying for, or offering to pay for, the salary or any part of the salary of a relative of any producer of title business which payment is in excess of the reasonable value of work performed by such relative on behalf of the title entity;

(16) paying, or offering to pay, any fee to any producer of title business for making an inspection or appraisal of property unless the fee bears a reasonable relationship to the services performed;

(17) paying for, or offering to pay for, services by any producer of title business which services are required to be performed by the producer of title business or title agency in his or her capacity as a real estate or mortgage broker or salesman or agent including but not limited to the drafting of documents that are required for the initiation of an escrow;

(18) furnishing or offering to furnish, paying for or offering to pay for, furniture, office supplies, telephones, facsimile machines, computer and other business equipment or automobile to any producer of title business, or paying for, or offering to pay for, any portion of the cost of renting, leasing, operating or maintaining any of the aforementioned items;

(19) paying for, furnishing, or waiving, or offering to pay for, furnish, or waive, all or any part of the rent for space occupied by any producer of title business;

(20) renting, or offering to rent space:

(A) from any producer of title business that does not serve a necessary purpose;

(B) at a rental rate which is excessive when compared with rental rates for comparable space in the geographic area; or

(C) paying, or offering to pay, rent based in whole or in part on the volume of business generated by any producer of title business;

(21) furnishing or offering to furnish, paying for or offering to pay for any economic opportunity, gift, gratuity, special discount, favor, hospitality, or service to any producer of title business having an aggregate value of $25 or more in any calendar year where a purpose of the donor is to influence any producer of title business in the placement of channeling of title insurance business. Hospitality in the form of incidental food and beverages are presumed not to be given to influence such producer of title business in the placement or channeling of title insurance business except when a particular transaction is conditioned thereon;

(22) paying for, or offering to pay for, money prizes or other things of value for any producer of title business in any kind of a contest or promotional endeavor. This prohibition applies whether or not the offer or payment of a benefit relates to the number of title orders placed or escrows opened with a title entity or group of such entities;

(23) paying for, or offering to pay for, any advertising for the benefit of the title entity through any advertising medium, the end result of which is the substantial subsidization of a product, service or publication used by, or published or printed by or for the benefit of, any producer of title business, building or financing businesses or any association or group of such persons. In determining whether there has been a violation of this subsection "substantial subsidization" will exist whenever 50 percent or more of the advertising revenue or printing costs, whichever is less, of any pamphlet, program, announcement, register, directory, index, book, brochure, periodical, newsletter, bulletin, information sheet or printed matter of any kind intended for distribution or circulation is paid for by one or more title entities;

(24) paying for, or furnishing, or offering to pay for or furnish, any advertising effort made in the name of, for, or on behalf of, any producer of title business through any advertising medium, whether or not the advertising is used, or is intended to be used, in connection with the promotion, sale or encumbrance of real property;

(25) paying for or furnishing, or offering to pay for or furnish, any business form to any producer of title business other than a form regularly used in the conduct of the title entity's business;

(26) giving of trading stamps, cash redemption coupons or similar items to any producer of title business;

(27) advancing or paying into escrow, or offering to advance or pay into escrow, any of the title entity funds;

(28) buying from or selling to, or exchanging with, or offering to buy from or sell to, or exchange with, any producer of title business, shares of stock, promissory notes or other securities in any title entity or any other business concern owned by, or affiliated with, a title entity, regardless of the price or relative value except for purchases or exchanges made through a general public offering. This prohibition also applies to the furnishing, or offer to furnish, legal or other

professional services by any title entity to any producer of title business or group of persons to assist such producer(s) of title business in the formation of a title entity. The burden will be placed on any existing title entity that invests in a title entity formed by one or more of such producer(s) of title business to show that such investment does not represent a benefit coming within the prohibition of this subsection; or

(29) charging, contracting or offering to contract with any producer of title business to perform services for which the title entity is making a charge either directly or indirectly. (Authorized by K.S.A. 40-103 and 40-2404a; implementing K.S.A. 40-2404(14) as amended by L. 1989, Ch. 139, Sec. 1; effective Oct. 23, 1989.)

40-3-43. Title insurance; controlled business; definitions; requirements. For purposes of K.S.A. 40-2404, (14)(f) through (i) and amendments thereto, these terms shall have the following meanings: (a) "Closed title order" shall mean an order when a policy or policies of title insurance are actually issued.

(b) "Controlled business" shall mean any portion of a title insurer's or title agent's business in this state that was referred by any producer of title business if the producer of title business with a financial interest in the title insurer or title agent to which the business is referred initiates the referral.

(c) "Title insurance order" shall mean an order for an owner's title insurance policy or an order for a loan policy of title insurance, or both. Each pair of orders for an owner's title insurance policy and a loan policy of title insurance to be issued simultaneously for the same real estate transaction shall constitute one order. The policies of title insurance issued under this transaction shall constitute one closed title order only if both policies are issued by the same title insurer or title agency. (Authorized by K.S.A. 40-103, K.S.A. 2004 Supp. 40-2404; implementing K.S.A. 2004 Supp. 40-2404; effective, T-40-7-27-89, July 27, 1989; effective Sept. 11, 1989; amended March 10, 2006.)

40-3-44. Automobile insurance; underwriting information; restrictions. (a) Except as otherwise specified in subsection (b), information regarding motor vehicle accidents, traffic violations, or related convictions occurring more than three years before the date of the application shall not be requested or utilized by insurers in connection with or in making an underwriting decision.

(b) Any information regarding convictions for violations enumerated in K.S.A. 8-285, and amendments thereto, occurring no more than five years before the date of the application may be utilized for underwriting purposes. (Authorized by K.S.A. 40-103 and 40-961; implementing K.S.A. 40-954; effective May 15, 1989; amended March 17, 2006.)

40-3-45. Fire and casualty insurance; rate filings; investment income; requirements. (a) Every rate filing required by K.S.A. 40-955 and amendments thereto shall include specific consideration of earnings or losses resulting from the investment of assets equal to the unearned premiums and loss reserves of the company or companies making the filing.

(b) These earnings or losses shall consist of the historical after-tax rate of return on net worth derived from investments and shall be calculated by developing an average rate of return as a percent of earned premiums. Any explanatory memorandum submitted with a rate filing shall include an explanation of how the investment earnings or losses are considered in the rate indications. The actual methodology used to derive the investment earnings or losses shall not be required to be included in the filing, but the methodology shall be made available upon the request of the commissioner. (Authorized by K.S.A. 40-103, K.S.A. 1998 Supp. 40-955, as amended by L. 1999, Ch. 63, § 2; implementing K.S.A. 1998 Supp. 40-955, as amended by L. 1999, Ch. 63, § 2; effective Aug. 14, 1989; amended March 24, 2000.)

40-3-46. (Authorized by K.S.A. 40-103 and L. 1990, Ch. 154, Secs. 1 and 2; implementing L. 1990, Ch. 154, Secs. 1 and 2; effective May 6, 1991; revoked March 10, 2006.)

40-3-47. Fire and casualty insurance; rating organizations; kinds of insurance affected. (a) Each rating organization shall develop and file only prospective loss costs for the following kinds of insurance and coverage:

(1) All lines of business specified in K.S.A. 40-901 and amendments thereto, except rates, rules, and forms filed by the midwest rating and service bureau, inc.; and

(2) all lines of business specified in K.S.A. 40-1102, and amendments thereto.

(b) For the filing of supplementary rating in-

formation by insurers any insurer may satisfy its obligation by performing the following:

(1) Referencing the prospective loss costs filed by a licensed rating organization; and

(2) completing and filing the information required by the Kansas insurance department's "policy and procedure regarding prospective loss costs filing," dated February 15, 2005, which is hereby adopted by reference. (Authorized by K.S.A. 40-103, 40-961(d); implementing K.S.A. 40-955; effective May 6, 1991; amended Feb. 8, 1993; amended March 28, 1994; amended March 10, 2006.)

40-3-48. Insurance companies; managing general agents; definitions; requirements. (a) The terms "managing general agent" and "MGA," as defined in K.S.A. 40-2,130(d) and amendments thereto, shall include any person who, in addition to the criteria set forth in that statute, adjusts or pays any claim in excess of $10,000 per claim or negotiates reinsurance on behalf of the insurer.

(b) The term "total annual written premium" shall include all direct premiums written by a managing general agent regardless of where the risks are located.

(c)(1) Each managing general agent shall acquire and maintain a fidelity bond for the protection of the insurer contracting with the managing general agent. The bond shall be in the amount of at least $100,000 or 10 percent of the managing general agent's total annual written premium nationwide that was produced by the MGA for the insurer in the prior calendar year. The bond shall not exceed $500,000. The bond amount shall be adjusted accordingly on or before April 1 of each year.

(2) Coverage shall not be written by the insurer or an affiliate of the insurer contracting with the managing general agent. The bond shall be executed by a fidelity insurer admitted to do business in Kansas, or an insurer appearing on the list maintained by the commissioner pursuant to K.S.A. 40-246e and amendments thereto, on a form supplied by the department.

(3) A copy of the executed bond shall be filed with the department.

(d) Each contract entered into between a managing general agent and a domestic insurer shall be retained by the insurer.

(e) Each managing general agent shall keep the usual and customary records pertaining to transactions taking place under the managing general agent agreements at the managing general agent's place of business. All books, bank accounts, and records shall be kept available and open to the inspection of the commissioner or the commissioner's representatives at any time during business hours. These records shall be retained by the managing general agent until the insurer and the business to which the records pertain has been the subject of an examination pursuant to the provisions of K.S.A. 40-222 and amendments thereto.

(f) If the contract between an insurer and a managing general agent is terminated for any reason, the managing general agent shall, upon request of the insurer, deliver all records to the insurer within 90 days of the request.

(g) Each managing general agent shall send the insurer a claim file when the managing general agent first knows that the claim might exceed a limit set by the insurer, or one-quarter of one percent of the policyholder surplus as reported in the last annual statement of the insurer, whichever is less.

(h) Each managing general agent shall send the insurer a claim file when the managing general agent first knows that the claim file is closed by payment of an amount set by the insurer, or an amount in excess of one-quarter of one percent of the policyholder surplus as reported in the last annual statement of the insurer, whichever is less.

(i) Each insurer licensed to write business in the state of Kansas shall file with the department, on or before March 1 of each year, a current list of names and addresses of all managing general agents with which the insurer has a contract and the name of an officer of the insurer responsible for the contract. The insurer shall provide written notification of changes to the list on a continuing basis.

(j) An independent audit by a certified public accountant shall be conducted annually upon managing general agents currently under contract and shall be contracted for by the insurer. The independent audit shall include the following:

(1) A report of an independent certified public accountant;

(2) a balance sheet;

(3) a statement of income;

(4) a statement of cash flows;

(5) a statement of income and retained earnings;

(6) the notes to financial statements required by generally accepted accounting principles; and

(7) a listing of all exceptions and internal control weaknesses noted in the course of the audit.

(k) Each insurer shall retain a current independent audit report by a certified public accountant of each managing general agent with which the insurer has done business.

(l) The authority to examine a managing general agent shall be retained by the commissioner, notwithstanding termination of the managing general agent's contractual authority. The insurer employing the managing general agent shall reimburse the department for the expense of the examination according to the provisions of K.S.A. 40-223 and amendments thereto. (Authorized by K.S.A. 40-103 and K.S.A. 40-2,136; implementing K.S.A. 40-2,130(d)(1), K.S.A. 2004 Supp. 40-2,131, K.S.A. 40-2,132, and K.S.A. 40-2,133; effective Dec. 16, 1991; amended Dec. 5, 2003; amended March 17, 2006.)

40-3-49. Fire and casualty insurance; modification of rate filing requirements; rates that cannot be practicably filed before use. (a) Any insurer or rating organization identifying those kinds of insurance, subdivisions, classes of risk, contracts, or combinations of these for which the required rating rule has been filed by the insurer with the commissioner shall retain in the underwriting file the rate or rating procedure used, which shall be made available to the commissioner upon request.

(b) Nothing in this regulation shall be construed as a suspension, preemption, or modification of any provision of K.S.A. 40-955 and amendments thereto, except as specifically permitted in this regulation. (Authorized by K.S.A. 40-103, 40-216, as amended by L. 1999, Ch. 63, § 1, and K.S.A. 1998 Supp. 40-955, as amended by L. 1999, Ch. 63, § 2; implementing K.S.A. 40-216, as amended by L. 1999, Ch. 63, § 1, and K.S.A. 1998 Supp. 40-955, as amended by L. 1999, Ch. 63, § 2; effective Jan. 4, 1993; amended May 16, 1997; amended March 24, 2000.)

40-3-50. (Authorized by K.S.A. 40-103; implementing K.S.A. 1992 Supp. 40-1117; effective Nov. 29, 1993; revoked June 3, 2005.)

40-3-52. Fire and casualty insurance; title insurers; controlled business arrangements. (a) For the purpose of this regulation, "controlled business" shall have the meaning specified in K.A.R. 40-3-43.

(b) As a part of the report stating the percentage of closed title orders originating from a controlled business arrangement pursuant to K.S.A. 40-2404(14)(h) and amendments thereto, each title insurer or title agent engaged in a controlled business arrangement shall submit the following information to the commissioner:

(1) The identity of each producer of title business involved in the controlled business arrangement;

(2) the date on which the business year began for the controlled business arrangement;

(3) the identity of any federally chartered bank or savings association affiliated with the title insurer, if such an affiliation exists; and

(4) the date of the end of the title insurer's or title agency's business year.

(c) Each insurer or title agent required by subsection (b) to file a report shall submit the report to the commissioner pursuant to K.S.A. 40-2404(14)(h) and amendments thereto. (Authorized by K.S.A. 40-103 and K.S.A. 2006 Supp. 40-2404(14)(j); implementing K.S.A. 40-2403 and K.S.A. 2006 Supp. 40-2404(14); effective Feb. 15, 2008.)

40-3-53. Fire and casualty insurance; electronic verification of insurance. (a) Each motor vehicle liability insurer writing insurance in the state shall provide the secretary of revenue with verification of each insured's insurance on-line or electronically by January 1, 2005. An exemption from this requirement may be granted upon request for any company that has less than 0.01 percent of the market share based on that company's commercial or personal automobile insurance written premiums or that has stated its intent to leave the automobile insurance market pursuant to K.S.A. 40-2,123 and amendments thereto. The 0.01 percent threshold shall be based on the specific line of coverage for which the company is seeking this exemption. Except as provided in subsection (b), the verification required by this subsection shall be in conformity with the following documents, which are hereby adopted by reference:

(1) The "Kansas insurance reporting guide," published by the Kansas department of revenue and dated November 2004; and

(2) the "Kansas insurance reporting map example," published by the Kansas department of revenue and dated July 2004.

(b) Any motor vehicle liability insurer that provided verification of insurance on-line or electronically before July 1, 2004 may continue to provide this verification in the same manner. (Authorized

by K.S.A. 40-103, K.S.A. 8-173, as amended by L. 2004, ch. 128, sec. 3(d); implementing K.S.A. 8-173, as amended by L. 2004, ch. 128, sec. 3(d); effective, T-40-12-29-04, Jan. 1, 2005; effective May 13, 2005.)

Article 4.—ACCIDENT AND HEALTH INSURANCE

40-4-1. Accident and health insurance; individual policies; rate filings; requirements. The national association of insurance commissioners' "guidelines for filing of rates for individual health insurance forms," July 1989 edition, is hereby adopted by reference subject to the following exceptions: (a) Section II, subsection A.2. is amended by the addition of the following sentence to the definition of "Optionally Renewable":

"Short-term major medical policies are considered to be optionally renewable."

(b) Section II, subsection A.3. is not adopted, and the following is substituted:

"When the expected average annual premium for a policy, including riders and endorsements, is $100 or more but less than $200, five percentage points shall be subtracted from the anticipated loss ratios shown in Section II A.1. If the expected average annual premium is less than $100, 10 percentage points shall be subtracted from the anticipated loss ratios shown in Section II A.1."

(c) Section II, subsection A.4. is not adopted.

(d) Section II, subsection A.8. is not adopted.

(e) Section II, subsection C.1.(b) is not adopted.

(f) The appendix is not adopted. (Authorized by K.S.A. 40-103 and 40-2215; implementing K.S.A. 40-2215; effective May 1, 1981; amended May 1, 1986; amended Oct. 17, 2003.)

40-4-2. Accident and sickness insurance policies; franchise plan; requirements. (a) Forms for accident and sickness insurance policies shall be approved for writing on a franchise plan when:

(1) Accident and sickness insurance on a franchise plan may be issued to:

(A) Three or more employees of any corporation, co-partnership, or individual employer, or any governmental corporation, agency or department; or

(B) 10 or more members of any trade or professional association, a labor union, or any other association that has been in active existence for at least two years when the association or union has a constitution or bylaws and is formed in good faith for purposes other than that of obtaining insurance; and

(2) Each person, with or without their dependents, will be issued the same individual policy form varying only as to amounts and kinds of coverage applied for, under an arrangement whereby the premiums on the policies may be paid to the insurer periodically by:

(A) The employer, with or without payroll deductions;

(B) the association for its members; or

(C) some designated person on behalf of the employer or association.

(b) The term "employees" includes the officers, managers, employees and retired employees of the employer and the individual proprietor or partners if the employer is an individual proprietor or partnership. (Authorized by K.S.A. 40-103, K.S.A. 1992 Supp. 40-2203(G); implementing K.S.A. 1992 Supp. 40-2215; effective Jan. 1, 1966; amended May 1, 1986; amended Nov. 29, 1993.)

40-4-3. Accident and health insurance policies; renewal and cancellation conditions; description required; cross-reference of renewal and cancellation provisions. (a) When an individual or family policy does not contain either a brief description or separate statement printed on the first page and on the filing back referring to the policy's renewal conditions, a separately captioned provision shall appear on the first page of the policy setting forth the conditions under which the policy may be renewed. The following captions shall be acceptable descriptions of the applicable renewal provisions:

Renewable At Option of Company

Guaranteed Renewable to Age 65 or Eligibility for Medicare—Premium rates may be changed on a class basis

Non-cancellable and Guaranteed Renewable to Age 65 or Eligibility for Medicare

Non-cancellable and Guaranteed Renewable to Age ( ) or—while actively or regularly employed to age ( ) * Guaranteed Renewable to Age ( ) or—while actively or regularly employed to age ( )—Premium rates may be changed on a class basis *

NOTE:

* (For disability income policies only. Insert minimum age of not less than 60 and maximum age of not less than 65.)

(b) Other captions may be submitted to the commissioner for approval and may be approved

if the commissioner determines that they are equally clear or more definite as to the subject matter.

(c) If the policy is not renewable, a statement to that effect shall appear in a separate provision on the first page of the policy.

(d) If the policy contains a cancellation provision, the cancellation provision shall appear separately, and shall be captioned "cancellation". The existence of the cancellation provision shall be referred to in the renewal provision by specific cross-reference in the renewal caption on the first page of the policy. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-2203(B)(8), 40-2215; effective Jan. 1, 1966; amended May 1, 1975; amended May 1, 1979; amended May 1, 1986.)

40-4-4. Accident and health insurance policies; limitation on the use of the terms "non-cancellable", "non-cancellable and guaranteed renewable" and "guaranteed renewable". (a) The terms "non-cancellable", "non-cancellable and guaranteed renewable", or "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums set forth in the policy until the age of 65 or to eligibility for medicare. During this period, the insurer shall not have any right to make any change unilaterally in any provision of the policy except as otherwise provided by this regulation.

(b) Each accident and health or accident only policy which provides for weekly or monthly payments, for a specified period during the continuance of a disability resulting from accident or sickness may provide that the insured has the right to continue the policy only to age 60 if, at age 60, the insured has the right to continue the policy in force at least to age 65 while regularly employed.

(c) Any insurer may make changes in premium rates by classes in policies using the term "guaranteed renewable".

(d) The foregoing limitation on use of the term "non-cancellable" shall also apply to any synonymous term such as "not cancellable" and the limitation on use of the term "guaranteed renewable" shall apply to any synonymous term such as "guaranteed continuable."

(e) The development of policies having other guarantees of renewability shall not be restricted. Accurate description of terms of renewability or classification of policies as "guaranteed renewable" or "non-cancellable" for any other specified period shall not be prohibited, if the terms used to describe them in policy contracts and advertising cannot readily be confused with the above terms. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-2215(C); effective Jan. 1, 1966; amended May 1, 1975; amended May 1, 1979; amended May 1, 1986.)

40-4-5. (Authorized by K.S.A. 40-103, 40-216, 40-2203(G), 40-2215(C); effective Jan. 1, 1966; amended Jan. 1, 1967; revoked May 1, 1979.)

40-4-6 to 40-4-11. (Authorized by K.S.A. 40-103, 40-216, 40-2203(G), 40-2215(C), 40-2403, 40-2404; effective Jan. 1, 1966; revoked May 1, 1979.)

40-4-12. Accident and health policies; application as part of the policy; notice required. (a) Each individual policy of accident, sickness, or hospitalization insurance shall not be delivered in this state unless the following notice is attached to the policy:

IMPORTANT NOTICE

Please read the copy of the application attached to this policy. Carefully check the application and write to _____ (Company), _____ (Address), within 10 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the policy and the policy was issued on the basis that answers to all questions and the information shown on the application are correct and complete.

(b) The statement, preferably in the form of a sticker to be placed on the policy, shall be printed in a prominent manner on paper or in ink of a contrasting color. The insurer may, with the approval of the commissioner, substitute similar wording. This rule shall not apply if the application for insurance is not attached to and made a part of the contract. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-2215; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986.)

40-4-13. Accident and health insurance; applications; "catchall" questions. An application for accident and health insurance shall not contain a nonspecific question concerning the general medical history of the applicant unless the question is limited in application to a specific period of time not in excess of five years. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-2215; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986.)

40-4-14 to 40-4-16. (Authorized by K.S.A. 40-103, 40-216, 40-246, 40-2203(G), 40-2215(C); effective Jan. 1, 1966; revoked May 1, 1979.)

40-4-17. Accident and health insurance companies; record of loss experience required; form adopted by the national association of insurance commissioners; filing date. (a) Each insurance company transacting accident and health insurance business in the state of Kansas shall maintain a record of country-wide loss experience for each policy form. The record shall be maintained on a "premium earned" and "losses incurred" basis or, optionally, on a "premium received" and "losses paid" basis.

(b) The insurance company shall maintain loss experience on each policy form currently issued and on any policy form not currently issued from which the renewal premiums represent five percent or more of the total premiums received.

(c) The insurance company shall record loss experience on total group business written. The insurance company need not maintain separation of loss experience on individual group policies.

(d) The insurance company shall report experience on the form adopted by the national association of insurance commissioners, as of 1994, which is hereby adopted by reference, and shall file the form not later than May 1 of each year. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-2215(C)(1); effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986; amended Feb. 9, 1996.)

40-4-18. Accident and health insurance companies; releases; requirements. Each insurance company writing health and accident insurance shall not limit or attempt to limit its liability under a contract by obtaining a release from the insured either in the form of enclosed check, proof of loss, or other release. The payment of benefits shall not be withheld on the grounds that the insured will not sign a release. Releases shall be permitted only where there is a definite question of liability and a compromise settlement is to be effected. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-2404; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986.)

40-4-19. (Authorized by K.S.A. 40-103, 40-216, 40-1109, 40-2203(G), 40-2215(C); effective Jan. 1, 1966; amended May 1, 1979; revoked May 1, 1986.)

40-4-20. (Authorized by K.S.A. 40-103, 40-235, 40-2403, 40-2404(l); effective Jan. 1, 1966; revoked May 1, 1979.)

40-4-21. Accident and health insurance; reserve standards for individual policies. The national association of insurance commissioners' reserve standards for individual health insurance policies, June 1985 edition, are hereby adopted by reference. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-234a; effective Jan. 1, 1968; amended May 1, 1986.)

40-4-22. Accident and health insurance policies; right to return policy. Each individual accident and health policy, except travel accident policies or policies of a similar type, issued for delivery in this state, shall have printed on, or attached to the first page of the policy, a notice stating that the person to whom the policy is issued shall be permitted to return the policy or contract within at least 10 days of its delivery to the purchaser and to have the premium paid refunded if purchaser dissatisfaction exists. The notice shall be printed in not less than 10 point type and shall be printed in bold face type or in some other manner that distinguishes it from the print otherwise appearing in the policy. When a policyholder or purchaser, pursuant to the notice, returns the policy to the company or association at its home or branch office or to the agent through whom it was purchased, the policy shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-2404 as amended by L. 1987, Ch. 171, Sec. 1; effective Jan. 1, 1972; amended May 1, 1975; amended May 1, 1979; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988.)

40-4-23. Accident and sickness insurance; deceptive practices; requirements; prohibitions. (a) Paragraphs (3), (4) and (5) of subsection (b) shall not apply to credit accident and sickness insurance, group accident and sickness insurance, nor to medicare supplement policies as defined in K.A.R. 40-4-35.

(b) Each authorized issuer of accident and sickness insurance contracts and each authorized insurance agent who solicits, negotiates or pro-

cures such insurance within this state shall meet the following requirements:

(1) Each agent shall, at the beginning of any solicitation, inform the prospective purchaser that he or she is acting as an insurance agent.

(2) The prospective purchaser shall be informed of the insurer's full name.

(3) The agent or insurer shall provide to the prospective purchaser before or with the delivery of a contract, a dated outline of coverage describing the elements of the contract including:

(A) The name and signature of the insurance agent, or if no agent is involved, the name of the employee of the insurer who assumes responsibility for completing the outline;

(B) the full name of the company writing the accident and sickness insurance;

(C) a statement identifying the applicable category or categories of coverage provided by the policy or contract and any supplemental riders as prescribed in K.S.A. 40-2218(a);

(D) a statement disclosing any provision in the policy or any supplemental riders which will reduce the benefits payable while the policy and riders are maintained in force on a premium-paying basis;

(E) the premiums for the accident and sickness insurance policy and a separate listing of the premiums for each optional or supplemental benefit provided by the contract;

(F) a statement disclosing the provisions of the policy and any supplemental riders relating to renewability, cancelability and termination and any modification of benefits, losses covered or premiums because of age or for other reasons. The description shall be written in a manner which will not minimize or render obscure the qualifying conditions;

(G) a statement disclosing those exceptions, reductions and limitations affecting the basic provisions of the policy and any supplemental riders;

(H) a statement disclosing the existence of any waiting, elimination, probationary or similar time period between the effective date of the policy and effective date of coverage under the policy and any supplemental riders, or a period of time between the date that loss occurs and the date the benefits begin to accrue for the loss;

(I) a statement disclosing the extent to which any loss is not covered under the policy and any supplemental riders, if the cause of the loss is traceable to a condition existing before the effective date of the policy or rider;

(J) a statement disclosing all the principal benefits provided by the policy or contract and any supplemental riders;

(K) a statement that the outline of coverage is a summary of the policy or contract and any supplemental riders issued or applied for and that the policy or contract and any supplemental riders should be consulted to determine governing contractual provisions; and

(L) if the policy or contract and any supplemental riders do not provide the standards for benefits promulgated by the commissioner, as provided in K.A.R. 40-4-24 through 40-4-33, a statement which clearly sets forth the policy restrictions.

(4) The outline of coverage shall accompany the policy. Alternatively, the outline may be delivered to the prospective purchaser at the time application is made, if an acknowledgment of receipt or certificate of delivery of the outline is obtained with the application. If an outline of coverage was delivered at the time of application, and the policy or contract is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or contract and any supplemental riders shall accompany the policy or contract and any supplemental riders when it is delivered. The substitute outline shall state clearly that the policy or contract and any supplemental riders are not the same as that for which application was made.

(5) The outline of coverage may consist of a separate written presentation or the outline may be included in the solicitation material advertising the policy. All information required to be disclosed shall be set out prominently in an uninterrupted sequence in one location in the separate, written presentation or advertising material. Additional material, other than that required, shall not be inserted between each required disclosure item. The style, arrangement and overall appearance of the outline of coverage shall not give any undue prominence to any portion of the text. Each printed portion of the text of the outline of coverage shall be plainly printed in lightfaced type of a style in general use. The size of the type shall be uniform and shall not be less than tenpoint with a lowercase, unspaced alphabet length not less than 120 point.

(c) Unfair or deceptive acts or practices in the selling of the insurance subject to this regulation shall include:

(1) Making any misrepresentation or false, deceptive or misleading statement;

(2) using comparisons or analogies or manipulating amounts and numbers in a way that will mislead the prospective purchaser concerning the cost of the insurance protection to be provided by the insurance contract, or any other significant aspect of the contract;

(3) referring to an insurance premium as a deposit, an investment, a savings, or using other similar phrases when referring to an insurance premium; and

(4) Recommending to a prospective purchaser the purchase or replacement of any accident and sickness insurance policy or contract with reasonable grounds to believe that the recommendation is unsuitable for the applicant on the basis of any information furnished by the person or otherwise obtained. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-2219, 40-2221; effective May 1, 1975; amended Feb. 15, 1977; amended May 1, 1979; amended May 1, 1982; amended May 1, 1986.)

40-4-24. (Authorized by K.S.A. 1978 Supp. 40-2218; effective Feb. 15, 1977; revoked May 1, 1979.)

40-4-25. Accident and sickness insurance standards for benefits. (a) K.A.R. 40-4-26 through 40-4-33 shall apply to each individual accident and sickness insurance policy and subscriber contract of hospital and medical and dental service corporations delivered or issued for delivery in this state. These regulations shall not apply to the following:

(1) A credit accident and health insurance policy subject to K.A.R. 40-5-102 through 40-5-110;

(2) an individual policy or contract issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when this group or individual policy or contract includes provisions that are inconsistent with the requirements of these regulations;

(3) a policy being issued to employees or members as additions to franchise plans in existence on the effective date of these regulations; and

(4) medicare supplement policies as defined in K.A.R. 40-4-35.

(b) The requirements in these regulations shall be in addition to the requirements in any other regulations previously adopted but shall not preclude the solicitation or issuance of policies or contracts that do not meet the standards for benefits set forth in K.A.R. 40-4-26 through 40-4-33. (Authorized by K.S.A. 40-103, 40-2218; implementing K.S.A. 40-2218; effective Feb. 15, 1977; amended May 1, 1979; amended May 1, 1982; amended May 1, 1986; amended March 31, 2006.)

40-4-26. Same; basic hospital expense coverage. (a) "Basic hospital expense coverage" means a policy of accident and sickness insurance which provides coverage for a period of not less than 31 days during any one period of confinement, for each person insured under the policy, and for expenses incurred for necessary treatment and services rendered as a result of accident and sickness. Minimum basic hospital expense coverage shall include the following:

(1) Daily hospital room and board in an amount not less than the lesser of:

(A) 80 percent of the charges for semi-private room accommodations; or

(B) $100 per day;

(2) miscellaneous hospital charges for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement, in an amount not less than either 80 percent of the charges incurred, up to at least $2,000, or 10 times the daily hospital room and board benefits; and

(3) Hospital outpatient services consisting of:

(A) Hospital services on the day surgery is performed;

(B) hospital services rendered within 72 hours after accidental injury, in an amount not less than $100; and

(C) x-ray and laboratory tests of not less than $200.

(b) benefits provided under paragraphs (1) and (2) of subsection (a) may be subject to a combined deductible amount not in excess of $100. (Authorized by K.S.A. 40-103, 40-2218; implementing K.S.A. 40-2218; effective Feb. 15, 1977; amended May 1, 1984; amended May 1, 1986.)

40-4-27. Same; basic medical-surgical expense coverage. "Basic medical-surgical expense coverage" means a policy of accident and sickness insurance which, for each person insured under the policy, provides coverage for the expenses incurred in providing the necessary services, rendered by a legally qualified physician, for treatment of an injury or sickness. Basic medical-surgical expense coverage shall provide at least the following:

(a) Surgical services consisting of benefits providing not less than:

(1) an amount for any procedure at least equal to $1,000, based on the relative values contained in the "relative value study" of the Kansas medical society, adopted May 5, 1966, as amended May 19, 1968; or

(2) 80 percent of the reasonable charges;

(b) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures, in connection with covered surgical service, which is rendered by a physician other than the physician or the physician's assistant performing the surgical services:

(1) In an amount not less than 80 percent of the reasonable charges; or

(2) 15 percent of the surgical service benefit;

(c) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than:

(1) 80 percent of the reasonable charges; or

(2) $10 per day for not less than 21 days during any one period of confinement. (Authorized by K.S.A. 40-103, 40-2218; implementing K.S.A. 40-2218; effective Feb. 15, 1977; amended May 1, 1984; amended May 1, 1986.)

40-4-28. Same; hospital confinement indemnity coverage. "Hospital confinement indemnity coverage" means a policy of accident and sickness insurance which provides, for each person insured under the policy, daily benefits for hospital confinement, on an indemnity basis, in an amount not less than $50 per day and for not less than 31 days during any one period of confinement. (Authorized by K.S.A. 40-103, 40-2218; implementing K.S.A. 40-2218; effective Feb. 15, 1977; amended May 1, 1984; amended May 1, 1986.)

40-4-29. Same; major medical expense coverage. (a) "Major medical expense coverage" means an accident and sickness insurance policy which:

(1) Provides hospital, medical and surgical expense coverage to an aggregate maximum of not less than $25,000;

(2) is not subject to a co-payment by the covered person of more than 25 percent of covered charges; and

(3) limits any deductible, stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of these bases, to five percent of the aggregate maximum limit under the policy.

(b) If the policy is written to complement underlying hospital and medical insurance, the deductible may be increased by the amount of the benefits provided by the underlying insurance.

(c) For each covered person, major medical expense coverage shall provide coverage for at least:

(1) Daily hospital room and board expenses of not less than $100 daily, prior to application of the co-payment percentage and for a period of not less than 31 days during any one period of confinement;

(2) miscellaneous hospital services, prior to application of the co-payment percentage, of an aggregate maximum of not less than $2,500 or 15 times the daily room and board rate, if specified in dollar amounts;

(3) surgical services, prior to application of co-payment percentage, of not less than $1,200 for the most severe operation, with the amounts provided for other operations reasonably related to the maximum amount;

(4) anesthesia services, prior to application of the co-payment percentage, of not less than 15 percent of the covered surgical fees. If the surgical schedule is based on a relative value schedule, coverage for anesthesia services shall not be less than the amount provided in the policy for anesthesia services at the same unit value used for the surgical schedule;

(5) in-hospital medical services, prior to application of the co-payment percentage, as defined in subsection (c) of K.A.R. 40-4-27;

(6) out-of-hospital care, prior to application of the co-payment percentage, consisting of physicians' services rendered on an ambulatory basis when coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and for diagnostic x-ray and laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(7) not fewer than three of the following additional benefits, prior to application of the co-payment percentage, for an aggregate maximum of the covered charges of not less than $2,000:

(A) In-hospital, private duty, graduate registered nurse services;

(B) convalescent nursing home care;

(C) diagnosis and treatment by a radiologist or physiotherapist;

(D) rental of special medical equipment, as defined by the insurer in the policy;

(E) artificial limbs or eyes, casts, splints, trusses or braces;

(F) treatment for functional nervous disorders, and mental and emotional disorders; and

(G) out-of-hospital prescription drugs and medications. (Authorized by K.S.A. 40-103, 40-2218; implementing K.S.A. 40-2218; effective Feb. 15, 1977; amended May 1, 1984; amended May 1, 1985; amended May 1, 1986.)

40-4-29a. Same; renewability of individual hospital, medical, or surgical expense policy. (a) Except as specificially authorized by K.S.A. 40-2257(b) and amendments thereto, an insurer shall not terminate an individual hospital, medical, or surgical expense policy for any insured who is eligible for Medicare if the insured wishes to continue the individual's coverage.

(b) Each insurer shall mail to its current individual medical policyholders approaching the age of 65 or Medicare eligibility explaining, in detail, the options available to them. The following notice shall be provided:

"IMPORTANT CONSUMER NOTICE

From Sandy Praeger, Commissioner of Insurance, State of Kansas

Dear Fellow Kansan,

Under the Federal Health Insurance Portability and Accountability Act and Kansas Statutes Annotated §40-2257, persons covered under an individual hospital, medical, or surgical expense policy may continue to renew this coverage even when they become eligible for Medicare. This means you may either:

- continue your current individual coverage into the future as long as you continue to pay premiums, **or**
- purchase a policy specifically designed to complement Medicare benefits, known as a Medicare supplement policy, once you are eligible for Medicare, **or**
- continue your current individual coverage **and** purchase a Medicare supplement policy.

The reason I am providing you with this information is to stress the importance of the decision you need to make. Each person who becomes enrolled for benefits in Medicare Part B receives a six (6)-month open enrollment period. During this six-month period, a person who applies for a Medicare supplement policy cannot be turned down and a policy will be issued to the applicant (subject to pre-existing condition limitations for some companies) without medical underwriting.

However, if you choose to maintain your current individual hospital, medical, or surgical policy after becoming enrolled in Medicare Part B, your six-month open enrollment period still begins to run. In general, this means that if you decide to apply for a Medicare supplement policy after the six-month period has passed, an insurance company may legally require you to meet its medical underwriting standards before issuing you such a policy.

You should also know that if you maintain your current individual policy and/or purchase a Medicare supplement policy, your premiums may increase as you get older. Neither policy will provide benefits that duplicate those provided by Medicare. In addition, although your current individual hospital, medical, or surgical expense policy may provide greater benefits than those offered through a Medicare supplement policy, you will likely be charged a greater premium rate and, in the long run, probably pay more for an individual hospital, medical, or surgical expense policy than a Medicare supplement policy. This is an important point to note and you should carefully compare and consider the cost of your current coverage and the benefits it provides, to the cost of a Medicare supplement policy and the benefits it provides.

Under the Federal Health Insurance Portability and Accountability Act and Kansas Statutes Annotated 40-2257, persons covered under an individual hospital, medical, or surgical expense policy may continue to renew this coverage, even when they become eligible for Medicare, except under very limited circumstances, such as when an insurer provides advance notice it is altogether ceasing to offer individual polices.

If you have any questions about your current coverage or purchasing a Medicare supplement policy, you may contact the Consumer Assistance Division of the Kansas Insurance Department at 1-800-432-2484 and one of our representatives will be glad to assist you.

Sandy Praeger
Commissioner of
Insurance"

(Authorized by K.S.A. 40-103 and 40-2257(i); implementing K.S.A. 40-2257; effective Jan. 12, 2007.)

40-4-30. Same; disability income protection coverage. (a) "Disability income protection coverage" means a policy which provides for weekly or monthly payments, for a specified period during the continuance of disability resulting from either sickness or injury, or a combination of both, and which:

(1) Provides that periodic payments which are payable at ages after 62 and reduced solely on the basis of age are at least 50 percent of amounts payable immediately prior to 62;

(2) Contains an elimination period no greater than:

(A) 90 days, in the case of coverage providing a benefit of one year or less;

(B) 180 days, in the case of coverage providing a benefit of more than one year but not greater than two years; or

(C) 365 days in all other cases.

(3) Has a maximum period of time for which benefits are payable during disability of at least six months. Reduction in benefits shall not be put into effect because of an increase in social security or similar benefits during a benefit period.

(b) This regulation does not apply to those policies providing business buy-out coverage. (Authorized by K.S.A. 40-103, 40-2218; implementing K.S.A. 40-2218; effective Feb. 15, 1977; amended May 1, 1986.)

40-4-31. Same; standards for benefits, accident only coverage. "Accident only coverage" means a policy of accident insurance which provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such policy shall be at least $1,000 and a single dismemberment amount shall be at least $500. (Authorized by K.S.A. 40-103, 40-2218; implementing K.S.A. 40-2218; effective Feb. 15, 1977; amended May 1, 1986.)

40-4-32. Same; standards for benefits; specified disease coverage. "Specified disease coverage" means a policy which meets one of the following definitions:

(a) A policy which provides coverage, for each person insured under the policy, for a specifically named disease or diseases with a deductible amount not in excess of $250, an overall aggregate benefit limit of no less than $10,000 and a benefit period of not less than two years for the following incurred expenses:

(1) Hospital room and board and any other hospital-furnished medical services or supplies;

(2) treatment by a legally qualified physician or surgeon;

(3) private duty services of a registered nurse (R.N.);

(4) x-ray, radium and other therapy procedures used in diagnosis and treatment;

(5) professional ambulance for local service to and from a local hospital;

(6) blood transfusions, including expense incurred for blood donors;

(7) drugs and medicines prescribed by a physician;

(8) rental of an iron lung or similar mechanical apparatus;

(9) braces, crutches and wheelchairs, as deemed necessary by the attending physician, for the treatment of the disease; and

(10) emergency transportation, if in the opinion of the attending physician, the insured requires transportation to another locality for treatment of the disease.

(b) A specified disease policy may include coverage of other expenses necessarily incurred in the treatment of the disease.

(c) A policy which provides coverage, for each person insured under the policy, for a specifically named disease or diseases with no deductible amount, an overall aggregate benefits limit of not less than $25,000, payable at the rate of not less than $50 a day while confined in a hospital, and a benefit period of not less than 500 days. (Authorized by K.S.A. 40-103, 40-2218; implementing K.S.A. 40-2218; effective Feb. 15, 1977; amended May 1, 1984; amended May 1, 1986.)

40-4-33. Same; standards for benefits; specified accident coverage. "Specified accident coverage" means an accident insurance policy which provides coverage for a specifically identified kind of accident or accidents for each person insured under the policy for accidental death or accidental death and dismemberment combined, with a benefit amount not less than:

(a) $1,000 for accidental death;

(b) $1,000 for double dismemberment; and

(c) $500 for single dismemberment. (Authorized by K.S.A. 40-103, 40-2218; implementing K.S.A. 40-2218; effective Feb. 15, 1977; amended May 1, 1986.)

40-4-34. Accident and health insurance; coordination of benefits; guidelines. Sections

3 through 9, including appendices A and B of the national association of insurance commissioners' "group coordination of benefits model regulation," January 1996 edition, are hereby adopted by reference subject to the following exceptions:

(a) Section 3(A)(1)(c) is not adopted and shall be replaced with the following language: "If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, or if one plan calculates its benefits or services on the basis of usual and customary fees and another plan provides its benefits or services on the basis of negotiated fees, any amount in excess of the highest of the fees is not an allowable expense."

(b) Section 3(A)(1)(d) is not adopted.

(c) Section (H)(3)(g) is not adopted.

(d) Section 3(H)(4)(k) is new and shall read as follows: "Plan shall not include group or group-type accident-only coverages."

(e) Section 3(H)(4)(f) is not adopted.

(f) Sections 8(B)(2) and (3) and (C) are not adopted and shall be replaced with the following language: "If the Noncomplying Plan reduces its benefits so that the employee, subscriber, or member receives less in benefits than he or she would have received had the Complying Plan paid or provided its benefits as the Secondary Plan and the Noncomplying Plan paid or provided its benefits as the Primary Plan, then the Complying Plan shall advance to or on behalf of the employee, subscriber, or member an amount equal to such difference. However, in no event shall the Complying Plan advance more than the Complying Plan would have paid had it been the Primary Plan less any amount it previously paid."

(g) Appendix A. Model COB contract provisions, sections (C)(3) and (4) are not adopted. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 1997 Supp. 40-2404; effective May 1, 1981; amended May 1, 1982; amended May 1, 1984; amended May 1, 1985; amended, T-86-13, May 9, 1985; amended May 1, 1986; amended May 1, 1987; amended Feb. 19, 1999.)

40-4-35. Medicare supplement policies; minimum standards; requirements. (a) The Kansas insurance department's "policy and procedure to implement medicare supplement insurance minimum standards," including the appendices, dated May 17, 2005, is hereby adopted by reference.

(b) This regulation shall supersede any other Kansas insurance department regulation to the extent that the other regulation or any provision of it is inconsistent with or contrary to this regulation.

(c) If any provision of the document adopted in subsection (a) or the application of any provision of this document to any person or circumstance is for any reason deemed invalid, the remainder of this regulation and the application of the provision to other persons or circumstances shall not be affected. (Authorized by K.S.A. 40-103, K.S.A. 40-2404a, and K.S.A. 40-2221; implementing K.S.A. 40-2215, K.S.A. 40-2221, and K.S.A. 40-2403; effective May 1, 1982; amended May 1, 1984; amended May 1, 1986; effective, T-40-12-16-88, Dec. 16, 1988; amended, T-40-3-31-89, March 31, 1989; amended June 5, 1989; amended Oct. 15, 1990; amended April 1, 1992; amended May 24, 1996; amended, T-40-3-18-99, April 29, 1999; amended Aug. 20, 1999; amended Jan. 1, 2001; amended Sept. 7, 2001; amended Aug. 26, 2005.)

40-4-35a. Medicare supplement policies; medicare catastrophic coverage repeal act of 1989; transitional requirements. Sections 3, 4, 5, 6, 7, 8, 9, 10 and appendix A of the national association of insurance commissioner's model regulation to implement transitional requirements for the conversion of medicare supplement insurance benefits and premiums to conform to repeal of medicare catastrophic coverage act, December 1989 edition, are hereby adopted by reference, subject to the following additions or exceptions:

(a) Section 5C.(2) is hereby amended to read as follows: "(2) Coverage for all of the medicare part A inpatient hospital deductible amount."

(b) Section 5D.(1) is hereby amended to read as follows: "(1) No later than January 31, 1990, every insurer, health care service plan or other entity providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contract holders and certificate holders of modifications it has made to medicare supplement insurance policies or contracts. Such notice shall be in the format adopted by the NAIC as appendix A."

(c) Section 5D.(1)(b) is hereby amended to read as follows: "(b) The notice shall inform each covered person as to when any premium adjustment resulting from changes in medicare benefits will be effective."

(d) Section 6C. is hereby amended to read as follows: "C. Any premium adjustments shall produce an expected loss ratio under such policy or contract necessary to conform with minimum loss ratio standards for medicare supplement policies and shall result in an expected loss ratio at least as great as that originally anticipated by the insurer, health care service plan or other entity for such medicare supplement insurance policies or contracts."

(e) The provisions entitled "accelerated policy adjustment procedures" included in the drafting note which follows section 6C. are not adopted. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-2221; effective, T-40-12-16-88, Dec. 16, 1988; effective May 15, 1989; amended April 16, 1990.)

40-4-36. Accident and sickness insurance; continuation and conversion policies; reasonable notice of right to continuation and right to convert. (a) The requirements for reasonable notice by the insurer of the right to continuation specified in K.S.A. 40-19c06 and K.S.A. 40-2209, and amendments thereto, shall be fulfilled if a form meeting the following requirements is transmitted to the insured person:

(1) Describes the right to continue coverage under the group policy;

(2) sets forth the premiums or subscriber's charges and mode of payment necessary to exercise this right; and

(3) describes the availability of types of coverage through the Kansas health insurance association.

(b) The form shall be directly delivered or transmitted to the last known address of the insured person.

(c) The requirements for reasonable notice by the insurer of the right to convert specified in K.S.A. 40-19c06 and K.S.A. 40-2209, and amendments thereto, shall be fulfilled if, during the six-month continuation period, a form meeting the following requirements is transmitted to the person eligible for conversion:

(1) Describes the conversion options;

(2) describes the premiums or subscriber's charges for each option;

(3) provides instructions regarding the action required to effect conversion; and

(4) describes the availability of types of coverage through the Kansas health insurance association.

(d) Insurers may include provisions in their group policies, subscription agreements, and certificates of coverage that are necessary to identify or obtain identification of persons and events that would activate the continuation and conversion rights created by K.S.A. 40-19c06 and K.S.A. 40-2209, and amendments thereto. (Authorized by K.S.A. 40-103, 40-19c06, and 40-2209; implementing K.S.A. 40-19c06 and 40-2209; effective, T-86-3, Jan. 9, 1985; effective May 1, 1985; amended May 1, 1986; amended May 29, 1998; amended April 25, 2003.)

40-4-37. Long-term care insurance; application; definitions. (a) These regulations shall apply to individual or group long-term care insurance policies, subscriber contracts, endorsements, and riders delivered or issued for delivery in this state by the following:

(1) Insurance companies;

(2) fraternal benefit societies;

(3) nonprofit hospital and medical service corporations; and

(4) health maintenance organizations.

(b) A policy, rider, or endorsement shall not be advertised, described, solicited, or issued for delivery in this state as long-term care insurance unless it conforms to the requirements of these regulations.

(c) As used in these regulations, these terms shall have the following meanings:

(1) "Long-term care insurance," "group long-term care insurance," "commissioner," "applicant," "certificate," and "policy" shall have the meanings set forth in K.S.A. 40-2227, and amendments thereto.

(2) "Medicare" means programs established by the "health insurance for the aged act," Title XVIII of the social security amendments of 1965, as then constituted or later amended.

(3) "Nursing facility" means a home, residence, or institution, other than a hospital, that is primarily engaged in providing nursing care and related services on an inpatient basis under a license issued by the appropriate licensing agency. A nursing facility may be a freestanding facility, including the following:

(A) Nursing facility;

(B) skilled nursing home;

(C) intermediate nursing care home;

(D) assisted living facility; and

(E) residential health care facility.

Each definition of a nursing facility shall adhere

to the above definition unless otherwise approved by the commissioner of insurance.

(4) No insurance carrier shall define "mental or nervous disorder" more restrictively than any of the following:

(A) Neurosis;

(B) psychoneurosis;

(C) psychopathy;

(D) psychosis; or

(E) any mental or emotional disease or disorder. However, no policy, contract, or rider shall exclude or limit benefits on the basis of organic brain disease, including Alzheimer's disease or senile dementia.

(5) The insurer may define "nurse" so that the description is restricted to a certain type of nurse, whether a registered graduate professional nurse, a licensed practical nurse, or a licensed vocational nurse. If the words "nurse," "trained nurse," or "registered nurse" are used without specific instruction, then the insurer shall recognize the services of any individual who qualified under this terminology in accordance with the applicable statutes or administrative regulations of the licensing or registry board of the state.

(6) The insurer may include the words "duly qualified physician" or "duly licensed physician" in its definition of "physician." An insurer using these terms shall recognize and accept, to the extent of its obligation under the contract, all providers of medical care and treatment when these services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(7) "Sickness" shall include an illness or disease of an insured person that first manifests itself after the effective date of insurance and while the insurance is in force. A definition of sickness may provide for a waiting period which shall not exceed 30 days after the effective date of the coverage of the insured person. The definition may be further modified to exclude illnesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

(8) "Guaranteed renewable" means both of the following:

(A) The insured may continue the long-term care insurance in force by the timely payment of premiums; and

(B) the insurer shall not unilaterally make any change in any provision of the policy or rider while the insurance is in force and shall not decline to renew the policy. However, the insurer may revise the rates on a class basis.

(9) "Noncancellable" means that the insured may continue the long-term care insurance in force by timely paying premiums during which period the insurer shall not unilaterally make any change in any provision of the insurance or in the premium rate.

(10) "Lapse" means termination of a policy due to the policyholder's failure to pay the premium within the time required.

(11)(A) "Exceptional increase" means only an increase filed by an insurer as exceptional for which the commissioner determines that the need for the premium rate increase is justified due to changes in laws or regulations applicable to long-term care coverage in this state, or due to increased and unexpected utilization that affects the majority of insurers of similar products.

(B) Exceptional increases shall be subject to the following:

(i) Except as provided in K.A.R. 40-4-37t, exceptional increases shall be subject to the same requirements as those for other premium rate schedule increases.

(ii) A review by an independent actuary or a professional actuarial body of the basis for a request than an increase be considered an exceptional increase may be requested by the commissioner.

(iii) Potential offsets to higher claim costs shall also be determined by the commissioner in determining that the necessary basis for an exceptional increase exists.

(12) "Incidental," as used in K.A.R. 40-4-37t(j), means that the value of the long-term care benefits provided is less than 10 percent of the total value of the benefits provided over the life of the policy. These values shall be measured from the date of issue.

(13) "Qualified actuary" means a member in good standing of the American academy of actuaries.

(14) "Similar policy forms" means all of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Certificates of groups that meet the definition in K.S.A. 40-2227(e), and amendments thereto, shall not be considered similar to certificates or policies otherwise issued as long-term care insurance, but shall be considered similar to other comparable certificates with the same long-

term care benefits classifications. For purposes of determining similar policy forms, long-term care benefit classifications shall be defined as follows:

(A) Institutional long-term care benefits only;

(B) noninstitutional long-term care benefits only; or

(C) comprehensive long-term care benefits.

(d) K.A.R. 40-4-37a, 40-4-37f, and 40-4-37i shall not apply to group long-term care insurance policies issued to an employer-employee group. (Authorized by K.S.A. 40-103, K.S.A. 40-2228; implementing K.S.A. 40-2228; effective, T-89-9, March 18, 1988; effective Sept. 12, 1988; amended Jan. 6, 1992; amended Jan. 4, 1993; amended Feb. 9, 1996; amended May 31, 2002.)

40-4-37a. Long-term care insurance; renewal provisions; requirements. (a) A certificate or individual policy delivered or issued for delivery shall not contain renewal provisions less favorable to the insured than "guaranteed renewable" for life. Any insurer may receive approval of another type of renewal provision if the insurer demonstrates to the satisfaction of the commissioner that the approval would be in recognition of the unique, developing and experimental nature of long-term care insurance.

(b) Individual long-term care insurance policies shall include a renewal provision which complies with subsection (a) of this regulation. The provision shall:

(1) Be appropriately captioned;

(2) appear on the first page of the policy; and

(3) clearly state the terms of renewability. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37b. Long-term care insurance; marketing practices; prohibitions; limitations. A policy shall not be advertised, described, solicited, delivered or issued for delivery in this state as long-term care insurance if the policy, contract or rider limits or excludes coverage by type of illness, treatment, medical condition or accident, except for the following:

(a) Mental or nervous disorders without demonstrable organic disease. This provision shall not exclude coverage for loss which results from organic brain disease, including alzheimer's disease or senile dementia;

(b) alcoholism and drug addiction;

(c) illness, treatment, medical condition or accident arising from:

(1) Participation in a felony, riot or insurrection;

(2) suicide, attempted suicide, or intentionally self-inflicted injury, whether sane or insane;

(3) aviation; or

(4) war or act of war, whether declared or undeclared;

(d) benefits provided under medicare or governmental programs other than medicaid, any state or federal workers' compensation or employer's liability or occupational disease law;

(e) services performed by a member of the covered person's immediate family; and

(f) services for which no charge is normally made in the absence of insurance. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37c. Long-term care insurance; termination; recurrent confinements; continuation of benefits. (a) If a long-term care insurance policy is terminated while an insured is confined in a nursing facility, benefits provided as a result of receiving nursing facility services shall continue until discharge from the nursing facility, expiration of the policy benefit period, if any, or payment of the maximum benefits for nursing facility services or maximum aggregate benefits under the policy, whichever comes first. For the purpose of this provision, continuous nursing confinement shall include transfer to another nursing facility or receiving another level of nursing care in a nursing facility. This subsection shall not apply if coverage under the policy terminates because of a lapse as defined in subsection (c) (11) of K.A.R. 40-4-37.

(b) A policy may contain a provision relating to recurrent confinements. However, a provision shall not specify that a recurrent condition be separated by a period greater than six months.

(c) Family coverage shall continue for any child who:

(1) is incapable of self-sustaining employment due to mental retardation or physical handicap on the date that the child's coverage would otherwise terminate under the policy due to the attainment of a specified age limit; and

(2) is chiefly dependent on the insured for support and maintenance. The policy may require that within 31 days of the date that the child's coverage would otherwise terminate, the insured must furnish the company due proof of the child's

incapacity and a notice of the insured's election to continue the policy in force with respect to the child, or the policy may require that a separate converted policy be issued at the option of the insured or policyholder. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37d. Long-term care insurance; benefits; medical condition; activities of daily living; definitions; requirements. (a) A long-term care policy may require a recommendation by a physician that the services are necessary due to illness, injury, or functional impairment but shall not condition benefits on medical necessity.

(b)(1) In addition to or in lieu of a recommendation by a physician as described in section (a) of this regulation, group long-term care insurance policies covering employees, dependents and retirees of a single employer may include provisions which condition the payment of benefits on an assessment of the insured's ability to perform activities of daily living or cognitive impairment.

(2) As used in this section, activities of daily living consist of the following defined activities and performance criteria:

(A) "Bathing" means the ability to get into and out of the tub or shower, turn on the water, get the soap or other cleansing product, and bathe the entire body including back and feet. A person is dependent if the person cannot bathe in a bathtub or shower without the assistance of another person or is able to participate only minimally, such as washing face and hands only.

(B) "Dressing" means the ability to get clothes from closets or drawers and put them on or take them off, including undergarments and outer-garments, as well as fasteners and braces, if worn. Dressing includes the ability to fasten one's shoes. A person is dependent if the person can dress only with the assistance of another person or is able to participate only minimally, such as putting on outer-garments only.

(C) "Eating" means the ability to bring food to the mouth or hold a glass to the mouth, and chew and swallow food. A person is dependent if the person is fed by hand, is being fed intravenously or through a feeding tube, is unable to bring food to the mouth or is unable to chew and swallow the food.

(D) "Maintaining continence" means the ability to maintain control of urination or bowel movement. A person is dependent if the person loses bladder control three times per week or more, loses bowel control two times per week or more, or needs assistance in maintaining a catheter or colostomy bag.

(E) "Toileting" means the ability to get to and from the toilet, onto and off the toilet, clean oneself after elimination, and adjust clothes after toileting. A person is dependent if the person needs help with one or more of these tasks, maintaining balance, or caring for a catheter or colostomy bag.

(F) "Transferring from bed to chair" means the ability to get into or out of bed or a chair. A person is dependent if the person is unable to get into or out of bed or a chair without human assistance.

(G) "Mobility" means the ability to walk or move from one place to another. A person is dependent if the person requires assistance or supervision from another person to safely walk or if the person needs to be wheeled from one place to another.

(3) "Cognitive impairment" means a deficiency in the ability to think, perceive, reason, remember or otherwise routinely display an ability to take care of oneself without the ongoing assistance of or supervision by another person.

(4) Any determination of impairment shall not be more restrictive than requiring either a deficiency in the ability to perform three of the activities of daily living or the presence of cognitive impairment.

(5) Only properly credentialed, experienced, trained professionals, such as physicians, registered nurses or licensed specialist social workers shall perform assessments of activities of daily living and cognitive impairment.

(6) Group long-term care insurance policies which condition the payment of benefits on an assessment of the insured's ability to perform activities of daily living or cognitive impairment shall include a clear and understandable description of the method for resolving insured grievances. (Authorized by K.S.A. 40-103, 40-2228; implementing K.S.A. 40-2228; effective, T-40-9-25-92, Sept. 25, 1992; effective Feb. 8, 1993; amended Feb. 9, 1996.)

40-4-37e. Long-term care insurance; prohibited policy provisions. A long-term care policy shall not:

(a) Contain an elimination period greater than

100 days for each period of confinement in a nursing home or for all confinements in a nursing home which are due to the same or related causes and separated from each other by less than six months;

(b) exclude coverage for confinement to an intermediate nursing facility when benefits are provided for nursing care;

(c) provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care;

(d) be delivered or issued for delivery to any person in this state unless every printed portion of the text of the policy is plainly printed in not less than 10 point type;

(e) require prior confinement to a hospital or prior confinement for a greater level of nursing care as a condition precedent to the payment of inpatient benefits;

(f) be delivered in this state unless the following notice is attached to the policy:

"IMPORTANT NOTICE"

"Please read the copy of the application attached to this policy. Carefully check the application and write to the company . . . (address) . . ., within 30 days, if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the policy and the policy was issued on the basis that answers to all questions and the information shown on the application are correct and complete."

This statement, preferably in the form of a sticker to be placed on the policy, shall be printed in a prominent manner on paper or in ink of a contrasting color. The insurer may, with the approval of the commissioner of insurance, substitute wording of similar import so long as equal results are obtained. This requirement shall not apply if the application for insurance is not attached to and made a part of the contract.

(g) be cancelled, nonrenewed or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(h) if it provides benefits for home health care or community care services, limit or exclude benefits:

(1) By requiring that the insured or claimant would need care in a skilled nursing facility if home health care services were not provided;

(2) by requiring that the insured or claimant first or simultaneously receive nursing or therapeutic services in a home, community or institutional setting before home health care services are covered;

(3) by limiting eligible services to services provided by registered nurses or licensed practical nurses;

(4) by requiring that a nurse or therapist provide services covered by the policy that can be provided by a home health aide, or other licensed or certified home care worker acting within the scope of the home care worker's licensure or certification;

(5) by excluding coverage for personal care services provided by a home health aide;

(6) by requiring that the provision of home health care services be at a level of certification or licensure greater than that required by the eligible service;

(7) by requiring that the insured or claimant have an acute condition before home health care services are covered;

(8) by limiting benefits to services provided by medicare-certified agencies or providers; or

(9) by excluding coverage for adult day care services. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37f. Long-term care insurance; notices, limited policy; right to return requirements. (a) A long-term care insurance policy shall have the words "this is a limited policy—read it carefully" printed on or attached to the face of the policy in not less than 18 point bold face type or in some other manner that distinguishes it from the print otherwise appearing in the policy.

(b) Right to return—free look provision. Long-term care insurance policies or certificates shall have a notice printed on or attached to the first page of the policy stating that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the insured person is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant or named insured by the insurer within 10 business days following receipt of the returned policy by the insurer or its agent. The notice required by this section shall be

printed in bold face type or in some other manner which distinguishes it from the print otherwise appearing in the policy. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37g. Long-term care insurance; benefit standards; definitions; explanations. (a) A long-term care insurance policy that provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import shall include a definition and an explanation of these terms in its accompanying outline of coverage.

(b) Definitions or provisions of the words "accident," "accidental injury," or "accidental means" shall not:

(1) Include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization;

(2) be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(3) Such definitions may provide that injuries shall not include injuries for which benefits are provided under workers' compensation, employer's liability or any similar law. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37h. Long-term care insurance; pre-existing conditions; requirements; prohibitions. (a) If a long-term care insurance policy or certificate contains any limitations with respect to pre-existing conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "pre-existing condition limitations."

(b) The definition of preexisting condition shall not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant, and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in K.S.A. 1991 Supp. 40-2228(e) (1) expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period of the policy or certificate.

(c) No long-term care insurance policy or certificate shall exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within the preexisting waiting period following the effective date of coverage of an insured person. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37i. Long-term care insurance; replacement; notice; waiver of waiting periods. (a) Long-term care insurance application forms shall request information as to other accident and health insurance coverage in force and whether the insurance to be issued is intended to replace any other accident and sickness policy presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(b) Upon determining that a sale will involve replacement, an insurer or its agent, other than a direct response insurer, shall furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, notice regarding replacement of accident and sickness coverage. One copy of the notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy the notice regarding replacement of accident and sickness coverage.

(c) If a long-term care policy replaces another long-term care policy issued by the company or an affiliated company, the replacing insurer shall waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods and probationary periods present in the new long-term care policy for similar benefits to the extent such time was spent under the original policy.

(d) Solicitations other than direct response. Upon determining that a sale will involve replacement, an insurer or its agent, other than an insurer using direct response solicitation methods, shall

furnish the applicant, prior to issuance or delivery of the individual long-term care insurance policy, a notice regarding replacement of accident and sickness or long-term care coverage. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. The required notice shall be provided in the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with an individual long-term care insurance policy to be issued by (company name) Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision. STATEMENT TO APPLICANT BY AGENT (BROKER OR OTHER REPRESENTATIVE): (Use additional sheets, as necessary.)

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

_____

(Signature of Agent, Broker or Other Representative)

(Typed Name and Address of Agent or Broker)

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's Signature)

(e) Direct response solicitations. Insurers using direct response solicitation methods shall deliver a notice regarding replacement of accident and sickness or long-term care coverage to the applicant upon issuance of the policy. The required notice shall be provided in the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with the long-term care insurance policy delivered herewith issued by (company name) Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long-term care coverage is a wise decision.

1. Health conditions which you may presently have (preexisting conditions), may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions or probationary periods. Your insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (company name and address) within 30 days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____

(Company Name)

(f) Where replacement is intended, the replacing insurer shall notify, in writing, the existing insurer of the proposed replacement. The existing policy shall be identified by the insurer, name of the insured and policy number or address including zip code. Such notice shall be made within five working days from the date the application is received by the insurer or the date the policy is issued, whichever is sooner.

(g)(1) Every insurer shall maintain records for each agent of the agent's amount of replacement sales as a percent of the agent's total annual sales and the amount of lapses of long-term care insurance policies sold by the agent as a percent of the agent's total annual sales.

(2) Each insurer shall, by June 30 of each year, report to the commissioner the names and addresses of the ten percent of its agents with the greatest percentages of lapses and replacements as measured by subsection (1) above.

(3) Reported replacement and lapse rates do not alone constitute a violation of insurance laws or imply wrongdoing. The reports are for the purpose of monitoring agent activities regarding the sale of long-term care insurance.

(4) Every insurer shall, by June 30 of each year, report to the commissioner the number of lapsed policies as a percent of its total number of policies sold and as a percent of its total number of policies in force as of the end of the preceding calendar year.

(5) Every insurer shall, by June 30 of each year, report to the commissioner the number of replacement policies sold as a percent of its total number of policies sold and as a percent of its total number of policies in force as of the preceding calendar year.

(6) For purposes of this section of this regulation, "policy" shall mean only long-term care insurance and "report" means on a statewide basis. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp.

40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37j. Long-term care insurance; outline of coverage; content; format. (a)(1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation. The outline of coverage shall prominently direct the attention of the recipient to such outline of coverage and explain its purpose.

(A) The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of the outline of coverage.

(B) In the case of agent solicitations, the agent shall deliver the outline of coverage prior to the presentation of an application or enrollment form.

(C) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.

(2) The outline of coverage shall display prominently by type, stamp or other appropriate means, on the first page of the outline of coverage and policy the following:

"Notice to buyer: This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations."

(3) The outline of coverage shall include:

(A) A description of the principal benefits and coverage provided in the policy;

(B) a statement of the principal exclusions, reductions, and limitations contained in the policy;

(C) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium. Continuation or conversion provisions of group coverage shall be specifically described;

(D) a statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(E) a description of the terms under which the policy or certificate may be returned and premium refunded;

(F) a brief description of the relationship of cost of care and benefits;

(G) a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. The graphic comparison shall show benefit levels over at least a 20 year period; and

(H) any expected premium increases or additional premiums to pay for automatic or optional benefit increases.

(b)(1) A long-term care insurance shopper's guide in the format developed by the national association of insurance commissioners, or a guide developed or approved by the commissioner, shall be provided to all prospective applicants of a long-term care insurance policy or certificate.

(A) In the case of agent solicitations, an agent must deliver the shopper's guide prior to the presentation of an application or enrollment form.

(B) In the case of direct response solicitations, the shopper's guide must be presented in conjunction with any application or enrollment form.

(2) Life insurance policies or riders containing accelerated long-term care benefits are not required to furnish the above referenced guide, but shall furnish the policy summary required under K.A.R. 40-2-20. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37k. Long-term care insurance; minimum loss ratios. (a) Long-term care insurance policies shall return the following to policyholders in the form of aggregate benefits under the policy:

(1) At least 65 percent of the aggregate amount of premiums earned in the case of group policies; and

(2) at least 60 percent of the aggregate amount of premiums earned in the case of individual policies.

(b) Subsection (a) of this regulation shall not apply to the following policies:

(1) Any long-term care policy or certificate issued in this state on or after January 1, 2003; and

(2) certficates issued on or after January 1, 2003 under group long-term care insurance policy as defined in K.S.A. 40-2227(e), and amendments thereto, if the policy was in force at the time this amended regulation became effective. Subsection (a) of this regulation shall not apply to the policy anniversary following 12 months after January 1, 2003.

(c) Insurers shall determine aggregate benefits returned under the policy on the basis of incurred claims experience and earned premiums for the entire period for which rates are computed, in ac-

cordance with accepted actuarial principles and practices.

(d) Long-term care benefits provided through the acceleration of the death benefit under a life insurance policy or annuity, if the payment of the long-term care benefits does not result in the decrease of the total amount of benefits payable under the policy, shall be subject to the following requirements in lieu of subsection (a), (b), or (c) of this regulation:

(1) The separately identifiable charge for the acceleration benefit shall not be excessive and shall meet either of the following criteria:

(A) Be a permanent and guaranteed charge; or

(B) have a guaranteed maximum cost that can never be increased.

(2) At the time of policy form filing, the insurer shall file a cost disclosure illustration with the insurance department.

(A) The cost disclosure illustration shall state separately the charges for the life insurance policy and for the accelerated death benefit provision provided for either in the policy or by rider, and the method of application of those charges.

(B) If the separately identifiable charge is illustrated as a percentage, the value or policy feature against which the percentage is to be applied shall also be disclosed.

(C) The cost disclosure illustration shall clearly state whether the accelerated death benefit provision is offered either as a permanent and guaranteed charge or with a guaranteed maximum cost. In policies offering a guaranteed maximum cost, the exact figure of the guaranteed maximum cost shall be clearly and unambiguously disclosed.

(3) At the time of delivery of the outline of coverage, a cost disclosure illustration identical to or substantially similar to that filed with the insurance department shall be delivered to the prospective applicant for review. The cost disclosure illustration shall include all the information required to be filed with the insurance department as set out in paragraphs (2)(A) and (B) of this subsection.

(4) The provisions of paragraphs (1)(A) and (B) shall not apply to and shall have no effect upon the underlying mortality costs and calculations that make up the basic premium for the life insurance policy itself.

(5) In the case of a single premium life insurance policy or annuity providing long-term care benefits via acceleration of the death benefit, the loss ratio requirements of this regulation shall be satisfied if the following conditions are met:

(A) Long-term care benefits are not separately terminated.

(B) At the time of policy form filing, the insurer files a benefit-to-premium illustration, relating cash values to premiums over a 15-year period of time, that is certified as appropriate by a member of the American academy of actuaries using the following assumptions:

(i) Mortality costs according to the appropriate percentage of the 1975-80 select and ultimate mortality tables as annually determined by the society of actuaries;

(ii) cash values calculated using minimum guaranteed interest and maximum total mortality and morbidity charges;

(iii) minimum reserves; and

(iv) lapses as follows:

1st year	20%
2nd year	15%
3rd year	13%
4th year	10%
5th year	8%
6th year through 14th year	7%
15th year	100%

The resulting benefit-to-premium ratio shall, in the aggregate, not be less than 75% when based upon an expected distribution of insureds for the age range for which the policy is issued.

(6) At the time of delivery of the single premium life policy or annuity, the insurer shall provide the policyholder with a cost disclosure setting out the year-by-year cash value increases on both a guaranteed and projected basis using current assumptions, for at least 20 years if any, and the total gross premium. The illustration shall include the following, clearly and unambiguously:

(A) A statement that specifies that the long-term care accelerated death benefit is an integral part of the policy or annuity and shall not be separately terminated;

(B) a statement of the maximum total charge for mortality and long-term care accelerated death benefit and the method of application of that charge; and

(C) a statement that the maximum total charge includes a charge for a long-term care accelerated death benefit. (Authorized by K.S.A. 40-103, K.S.A. 40-2228; implementing K.S.A. 40-2228; effective Jan. 4, 1993; amended Aug. 16, 2002.)

40-4-37*l*. Long-term care insurance; applications. All applications for long-term care insurance policies or certificates, except those which are guaranteed issue, shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant.

(a)(1) If an application for long-term care insurance contains a question which asks whether the applicant has had medication prescribed by a physician, it must also ask the applicant to list the medication that has been prescribed.

(2) If the medications listed in such application were known by the insurer, or should have been known at the time of application, to be directly related to a medical condition for which coverage would otherwise be denied, then the policy or certificate shall not be rescinded for that condition.

(3) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another long-term care insurance policy or certificate in force or whether a long-term care policy or certificate is intended to replace any other accident and sickness or long-term care policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used. With regard to a replacement policy issued to a group defined by K.S.A. 1991 Supp. 40-2209(3), if the certificateholder has been notified of the replacement, the following questions may be modified only to the extent necessary to elicit information about health or long-term care insurance policies other than the group policy being replaced.

(A) Do you have another long-term care insurance policy or certificate in force (including health care service contract, health maintenance organization contract)?

(B) Did you have another long-term care insurance policy or certificate in force during the last 12 months?

(i) If so, with which company?

(ii) If that policy lapsed, when did it lapse?

(C) Are you covered by medicaid?

(D) Do you intend to replace any of your medical or health insurance coverage with this policy (certificate)?

(b) Agents shall list any other health insurance policies they have sold to the applicant:

(1) Which are still in force; and

(2) in the past five years which are no longer in force.

(c) Except for policies or certificates which are guaranteed issue:

(1) The following language shall be set out conspicuously and in close conjunction with the applicant's signature block on an application for a long-term care insurance policy or certificate:

> Caution: If your answers on this application are incorrect or untrue, (company) has the right to deny benefits or rescind your policy.

(2) The following language, or language substantially similar to the following, shall be set out conspicuously on the long-term care insurance policy or certificate at the time of delivery:

> Caution: The issuance of this long-term care insurance (policy) (certificate) is based upon your responses to the questions on your application. A copy of your (application) (enrollment form) (is enclosed) (was retained by you when you applied). If your answers are incorrect or untrue, the company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the company at this address: (insert address).

(3) Prior to issuance of a long-term care policy or certificate to an applicant age 80 or older, the insurer shall obtain one of the following:

(A) A report of a physical examination;

(B) an assessment of functional capacity;

(C) an attending physician's statement; or

(D) copies of medical records.

(d) A copy of the completed application or enrollment form (whichever is applicable) shall be delivered to the insured no later than at the time of delivery of the policy or certificate unless it was retained by the applicant at the time of application. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37m. Long-term care insurance; rescissions; annual report required. Every insurer or other entity selling or issuing long-term care insurance benefits shall maintain a record of all policy or certificate rescissions, both state and countrywide, except those which the insured voluntarily effectuated and shall annually furnish this

information to the insurance department in the format prescribed by the commissioner. This information shall be provided for each rescission no later than March 1 of the calendar year following the date of rescission. This information shall include:

(a) Policy form number;

(b) policy and certificate number;

(c) name of insured;

(d) date of policy issuance;

(e) date each claim is submitted;

(f) date of rescission; and

(g) detailed reason for rescission. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37n. Long-term care insurance; home health or community care services. (a) A long-term care insurance policy or certificate, if it provides for home health or community care services, shall provide total home health or community care coverage that is a dollar amount equivalent to at least one-half of one year's coverage available for nursing home benefits under the policy or certificate at the time covered home health or community care services are being received. This requirement shall not apply to policies or certificates issued to residents of continuing care retirement communities.

(b) Home health care coverage may be applied to the non-home health care benefits provided in the policy or certificate when determining maximum coverage under the terms of the policy or certificate. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37o. Long-term care insurance; inflation protection; increased benefits; offer required. (a) No insurer may offer a long-term care insurance policy unless the insurer also offers to the policyholder, in addition to any other inflation protection, the option to purchase a policy that provides for benefit levels to increase with benefit maximums or reasonable durations which are meaningful to account for reasonably anticipated increases in the costs of long-term care services covered by the policy. Insurers shall offer to each policyholder, at the time of purchase, the option to purchase a policy with an inflation protection feature no less favorable than one of the following:

(1) Benefit levels increase annually in a manner so that the increases are compounded annually at a rate not less than five percent;

(2) the insured individual is guaranteed the right to periodically increase benefit levels, without providing evidence of insurability or health status, so long as the option for the previous period has not been declined. The amount of the additional benefit shall be no less than the difference between the existing policy benefit and that benefit compounded annually at a rate of at least five percent for the period beginning with the purchase of the existing benefit and extending until the year in which the offer is made; or

(3) a specified percentage of actual or reasonable charges are covered and a maximum specified indemnity amount or limit is not included.

(b) Where the policy is issued to a group, the required offer in subsection (a) above shall be made to the group policyholder and each proposed certificateholder.

(c) The offer in subsection (a) above shall not be required for life insurance policies or riders containing accelerated long-term care benefits.

(d) Inflation protection benefit increases under a policy which contains such benefits shall continue without regard to an insured's age, claim status or claim history, or the length of time the person has been insured under the policy.

(e) An offer of inflation protection which provides for automatic benefit increases shall include an offer of a premium which the insurer expects to remain constant. Such offer shall disclose in a conspicuous manner that the premium may change in the future unless the premium is guaranteed to remain constant.

(f)(1) Inflation protection as provided in subsection (a)(1) of this section shall be included in a long-term care insurance policy unless an insurer obtains a rejection of inflation protection signed by the policyholder as required in this subsection.

(2) The rejection of inflation protection shall be considered a part of the application and shall state:

> I have reviewed the outline of coverage and the graph or graphs contained therein that compare the benefits and premiums of this policy with and without periodic increases in benefits to provide inflation protection. Specifically, I have reviewed the plans offered by the insurer, and I reject inflation protection.

(Authorized by K.S.A. 40-103, K.S.A. 1991 Supp.

40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37p. Long-term care insurance; advertisements; marketing. (a) Every insurer, health care service plan or other entity providing long-term care insurance or benefits in this state shall provide a copy of any long-term care insurance advertisement intended for use in this state, whether through written, radio or television medium, to the commissioner of insurance of this state for review or approval by the commissioner to the extent it may be required under state law. In addition, all advertisements shall be retained by the insurer, health care service plan or other entity for at least three years from the date the advertisement was first used.

(b) The commissioner may exempt from these requirements any advertising form or material, when in the commissioner's opinion, this requirement may not be reasonably applied.

(c)(1) Every insurer, health care service plan or other entity marketing long-term care insurance coverage in this state, directly or through its producers, shall:

(A) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;

(B) establish marketing procedures to assure excessive insurance is not sold or issued;

(C) inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for long-term care insurance already has accident and sickness or long-term care insurance and the types and amounts of any such insurance;

(D) establish auditable procedures for verifying compliance with this subsection (1); and

(E) provide written notice to the prospective policyholder and certificateholder at solicitation that a senior insurance counselling, senior citizen seminars and other information services programs are available through the Kansas Department on Aging and Kansas Insurance Department and the address and telephone number of such agencies.

(2) In addition to the practices prohibited in K.S.A. 1991 Supp. 40-2404, the following acts and practices are prohibited:

(A) Twisting. Twisting is knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert any insurance policy or to take out a policy of insurance with another insurer.

(B) High pressure tactics. High pressure tactics include employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(C) Cold lead advertising. Cold lead advertising is making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37q. Initial filing requirements. (a) This regulation shall apply as follows:

(1) To any long-term care policy issued in this state on or after January 1, 2003; or

(2) for certificates issued on or after January 1, 2003 under a group long-term care insurance policy as defined in K.S.A. 40-2227(e), and amendments thereto, which policy was in force at the time this regulation became effective, on the policy anniversary following 12 months after January 1, 2003.

(b)(1) Each insurer shall provide the following information and, as required, the information specified in paragraph (b)(2)(A), (B), or (C) to the commissioner 30 days before making a long-term care insurance form available for sale:

(A) A copy of the disclosure documents required in K.A.R. 40-4-37s; and

(B) an actuarial certification containing the following:

(i) A statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(ii) a statement that the policy design and coverage provided have been reviewed and taken into consideration;

(iii) a statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration; and

(iv) a statement that the premium rate sched-

ule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits or a comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences.

(2) In addition to providing the information specified in paragraph (b)(1), each insurer shall also furnish information that provides a complete description of the basis for contract reserves that are anticipated to be held under the form, which shall include the information specified in paragraph (b)(2)(A), (B), or (C):

(A)(i) Sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(ii) a statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(iii) a statement that the net valuation premium for renewal years does not increase, except for attained-age rating where permitted; and

(iv) a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses or, if such a statement cannot be made, a complete description of the situations in which this does not occur;

(B) if the insurer does not provide the statement required in paragraph (b)(2)(A)(iv), an aggregate distribution of anticipated issues, if the underlying gross premiums maintain a reasonably consistent relationship; or

(C) if the insurer does not provide the information required in either paragraph (b)(2)(A)(iv) or paragraph (b)(2)(B), and if the gross premiums for certain age groups appear to be inconsistent with this requirement, a demonstration under subsection (c) of this regulation, based on standard age distribution as may be requested by the commissioner.

(c) An actuarial demonstration that benefits are reasonable in relation to premiums and that shall include one of the following, or both, may be requested by the commissioner:

(1) Premium and claim experience on similar policy forms, adjusted for any premium or benefit differences; or

(2) relevant and credible data from other studies.

(d) If the commissioner asks for additional information under subsection (c) of this regulation, the time period specified in subsection (a) of this regulation shall not include the period during which the insurer is preparing the requested information. (Authorized by K.S.A. 40-103 and K.S.A. 40-2228; implementing K.S.A. 40-2228; effective Aug. 16, 2002.)

40-4-37r. Long-term care insurance; non-duplication provisions. A long-term care policy may contain non-duplication of coverage provisions consistent with Kansas insurance statutes, administrative regulations or which have been specifically approved by the commissioner. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-2228; implementing K.S.A. 1991 Supp. 40-2228; effective Jan. 4, 1993.)

40-4-37s. Long-term care insurance; required disclosure of rating practices to consumers. (a) Except as provided in subsection (b) of this regulation, this regulation shall apply to any long-term care policy or certificate issued in this state six or more months after the adoption of this regulation.

(b) For certificates issued on and after the effective date of this regulation under a group long-term care insurance policy as defined in K.S.A. 40-2227(e) and amendments thereto, which policy was in force at the time this regulation became effective, the provisions of this regulation shall apply on the policy anniversary following the date that is 12 months after the adoption of this regulation.

(c) Other than for policies for which no applicable premium rate or rate schedule increases can be made or for which the method of application does not allow for delivery at the time of application or enrollment, each insurer shall provide all the following information to the applicant at the time of application or enrollment.

(1) A statement that the policy may be subject to rate increases in the future;

(2) an explanation of potential future premium rate revisions, and the policyholder's or certificate holder's option in the event of a premium rate revision;

(3) the premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(4) a general explanation for applying premium rate or rate schedule adjustments that shall include the following:

(A) A description of when premium rate or rate

schedule adjustments will be effective, including the next anniversary date, next billing date; and

(B) the right to a revised premium rate or rate schedule as specified in paragraph (c)(2) of this regulation if the premium rate or rate schedule is changed;

(5) information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this state or any other state that, at a minimum, identifies the following:

(A) The policy forms for which premium rates have been increased;

(B) the calendar years when the form was available for purchase; and

(C) the amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate before the increase, and may also be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(d)(1) The insurer may, in a fair manner, provide additional explanatory information related to rate increases.

(2) Each insurer shall have the right to exclude from the disclosure premium rate increases that apply only to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers if those increases occurred before the acquisition.

(3) If an acquiring insurer files for a rate increase on a long-term care policy form acquired from nonaffiliated insurers or a block of policy forms acquired from nonaffiliated insurers on or before the later of the effective date of this regulation, or the end of a 24-month period following the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling company shall include the disclosure of that rate increase in accordance with paragraph (c)(5) of this regulation.

(4) If the acquiring insurer described in paragraph (d)(3) of this regulation files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from nonaffiliated insurers or block of policy forms acquired from nonaffiliated insurers referenced in paragraph (d)(3) of this regulation, the acquiring insurer shall make all disclosures required by paragraph (c)(5) of this regulation, including disclosure of the earlier rate increase referenced in paragraph (d)(3) of this regulation.

(e) Each applicant shall sign an acknowledgement at the time of application, unless the method of application does not allow for signature at that time, that the insurer made the disclosures required under paragraphs (c)(1) and (5) of this regulation. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(f) Each insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, if applicable, at least 45 days before the implementation of the premium rate increase by the insurer. The notice shall include the information required by subsection (c) of this regulation when the rate increase is implemented.

(g) Each insurer shall use the forms found in appendices B and F of the national association of insurance commissioners' "long-term care insurance model regulation," June 13, 2000 edition, which are hereby adopted by reference, to comply with the requirements of subsections (a), (b), and (c) of this regulation. (Authorized by K.S.A. 40-103 and K.S.A. 40-2228; implementing K.S.A. 40-2228; effective May 31, 2002.)

40-4-37t. Premium rate schedule increases. (a) This regulation shall apply as follows:

(1) Except as provided in paragraph (a)(2) of this regulation, to any long-term care policy or certificate issued in this state on or after January 1, 2003; or

(2) for certificates issued on or after January 1, 2003 under a group long-term care insurance policy as defined in K.S.A. 40-2227(e) and amendments thereto, which policy was in force when this regulation became effective, on the policy anniversary following 12 months after January 1, 2003.

(b) Each insurer shall provide notice of a pending premium rate schedule increase, including an exceptional increase, to the commissioner at least 30 days before the notice to the policyholders and shall include the following:

(1) Information required by K.A.R. 40-4-37s;

(2) certification of both of the following by a qualified actuary:

(A) If the premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized, no further premium rate schedule increases are anticipated; and

(B) the premium rate filing is in compliance with the provisions of this regulation;

(3) an actuarial memorandum justifying the rate schedule change request that includes the following:

(A) Lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale:

(i) Annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(ii) the projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(iii) the projections shall demonstrate compliance with subsection (c); and

(iv) for exceptional increases, the projected experience shall be limited to the increases in claims expenses attributable to the approved reasons for the exceptional increase. If the commissioner determines as provided in K.A.R. 40-4-37(c)(11) that offsets may exist, the insurer shall use appropriate net projected experience;

(B) disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(C) disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the company have been relied on by the actuary;

(D) a statement that policy design, underwriting, and claims adjudication practices may have been taken into consideration; and

(E) if it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase, composite rates filed by the insurer reflecting projections of new certificates;

(4) a statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the commissioner; and

(5) sufficient information for review before use of the premium rate schedule increase by the commissioner.

(c) All premium rate schedules shall be determined in accordance with the following requirements:

(1) Exceptional increases shall provide that 70 percent of the present value of projected additional premiums from the exceptional increase will be returned to policyholders in benefits.

(2) Premium rate schedule increases shall be calculated so that the sum of the accumulated value of incurred claims without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(A) The accumulated value of the initial earned premium times 58 percent;

(B) 85 percent of the accumulated value of prior premium rate schedule increases on an earned basis;

(C) the present value of future projected initial earned premiums times 58 percent; and

(D) 85 percent of the present value of future projected premiums not included in paragraph (c)(2)(C) of this regulation on an earned basis;

(3) If a policy form has both exceptional and other increases, the values in paragraphs (c)(2)(B) and (D) of this regulation shall also include 70 percent for exceptional rate increase amounts.

(4) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in K.S.A. 40-409, and amendments thereto. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(d) For each rate increase that is implemented, the insurer shall file before use for review by the commissioner updated projections, as defined in paragraph (b)(3)(A) of this regulation, annually for the next three years and shall include a comparison of actual results to projected values. The period may be extended by the commissioner to greater than three years if actual results are not consistent with projected values for prior projections. For group insurance policies that meet the conditions in subsection (k) of this regulation, the projections required by subsection (d) shall be provided to the policyholder in lieu of filing with the commissioner.

(e) If any premium rate in the revised premium rate schedule is greater than 200 percent of the comparable rate in the initial premium schedule, lifetime projections, as defined in paragraph (b)(3)(A) of this regulation, shall be filed for re-

view by the commissioner before use every five years following the end of the required period in subsection (d) of this regulation. For group insurance policies that meet the conditions in subsection (k) of this regulation, the projections required by subsection (e) shall be provided to the policyholder in lieu of filing with the commissioner.

(f)(1) If the commissioner has determined that the actual experience following a rate increase does not adequately match the projected experience and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed the proportions of premiums specified in subsection (c) of this regulation, the insurer may be required by the commissioner to implement either of the following:

(A) Premium rate schedule adjustments; or

(B) other measures to reduce the difference between the projected and actual experience.

(2) In determining whether the actual experience adequately matches the projected experience, consideration shall be given to paragraph (b)(3)(E) of this regulation, if applicable.

(g) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file the following:

(1) A plan, subject to commissioner approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect. If this plan fails to eliminate the potential for further deterioration of the policy form, the conditions in subsection (h) of this regulation may be imposed by the commissioner; and

(2) the original anticipated lifetime loss ratio and the premium rate schedule increase that would have been calculated according to subsection (c) of this regulation if the greater of the original anticipated lifetime loss ratio or 58 percent had been used in the calculations described in paragraphs (c)(2)(A) and (C) of this regulation.

(h)(1) For a rate increase filing and all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months following each increase shall be reviewed by the commissioner to determine if a significant adverse lapsation has occurred or is anticipated and meets the following criteria:

(A) The rate increase is not the first rate increase requested for the specific policy form or forms;

(B) the rate increase is not an exceptional increase; and

(C) the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefits upon lapse.

(2) If a significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer following the requested rate increase, a determination that a rate spiral exists may be made by the commissioner. Following the determination that a rate spiral exists, the insurer may be required by the commissioner to offer, without underwriting, to all insureds subject to the rate increase the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(A) The offer shall meet the following conditions:

(i) Be subject to the approval of the commissioner;

(ii) be based on actuarially sound principles, but not be based on attained age; and

(iii) provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(B) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of the following:

(i) The maximum rate increase determined based on the combined experience; or

(ii) the maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10 percent.

(i) If the commissioner determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, in addition to the provisions of subsection (h) of this regulation, the insurer may be prohibited by the commissioner from either of the following:

(1) Filing and marketing comparable coverage for a period of up to five years; or

(2) offering all other similar coverage and limiting marketing of new applications to the prod-

ucts subject to recent premium rate schedule increases.

(j) Subsections (a) through (i) of this regulation shall not apply to policies with the long-term care benefits provided by the policy age incidental as defined in K.A.R. 40-4-37 (c)(12), if the policy complies with all of the following provisions:

(1) The interest credited internally to determine cash value accumulations, including long-term care, if any, is guaranteed not to be less than the minimum guaranteed interest rate for cash value accumulations without long-term care set forth in the policy.

(2) The portion of the policy that provides insurance benefits other than long-term care coverage meets the nonforfeiture requirement as applicable in any of the following:

(A) K.S.A. 40-428, and amendments thereto;

(B) K.S.A. 40-428a, and amendments thereto; and

(C) K.A.R. 40-15-1.

(3) The policy meets the disclosure requirements of K.S.A. 40-2228(g), and amendments thereto, and K.A.R. 40-2-25.

(4) The portion of the policy that provides insurance benefits other than long-term care coverage meets the requirements, as applicable, in the following:

(A) Policy illustrations as required by K.A.R. 40-2-25;

(B) disclosure requirements in K.A.R. 40-2-25; and

(C) disclosure requirements in K.A.R. 40-15-1.

(5) An actuarial memorandum is filed with the insurance department that includes the following:

(A) A description of the basis on which the long-term care rates were determined;

(B) a description of the basis for the reserves;

(C) a summary of the type of policy, benefits, renewability, general marketing method, and limits on ages of issuance;

(D) a description and a table of each actuarial assumption used. For expenses, each insurer shall include the percent of premium dollars per policy and dollars per unit of benefits, if any;

(E) a description and a table of the anticipated policy reserves and additional reserves to be held in each future year for active lives;

(F) the estimated average premium per policy and the average issue age;

(G) a statement as to whether underwriting is performed at the time of application. The statement shall indicate whether underwriting is used, and if used, the statement shall include a description of the type or types of underwriting used, including medical underwriting and functional assessment underwriting. Concerning a group policy, the statement shall indicate whether the enrollee or any dependent will be underwritten and when underwriting will occur; and

(H) a description of the effect of the long-term care policy provisions on the required premiums, nonforfeiture values, and reserves on the underlying insurance policy, both for active lives and those in long-term care claim status.

(k) Subsections (f) and (h) of this regulation shall not apply to group insurance policies as defined in K.S.A. 40-2209(f)(l) through (6), and amendments thereto, if either of the following conditions is met:

(1) The policies insure 250 or more persons, and the policyholder has 5,000 or more eligible employees of a single employer.

(2) The policyholder, and not the certificate holder, pays a material portion of the premium, which shall not be less than 20 percent of the total premium for the group in the calendar year before the year a rate increase is filed. (Authorized by K.S.A. 40-103 and K.S.A. 40-2228; implementing K.S.A. 40-2228; effective Aug. 16, 2002.)

40-4-37u. Contingent-benefit-upon-lapse requirement. (a) This regulation shall not apply to life insurance policies or riders containing accelerated long-term care benefits.

(b) Each long-term care policy or certificate issued in this state shall offer a nonforfeiture benefit subject to the following requirements:

(1) A policy or certificate offered with nonforfeiture benefits shall have coverage elements, eligibility, benefit triggers, and benefit lengths that are the same as coverage to be issued without nonforfeiture benefits. The nonforfeiture benefit included in the offer shall be the benefits described in subsection (f) of this regulation; and

(2) the offer shall be in writing if the nonforfeiture benefit is not otherwise described in the outline of coverage or other materials given to the prospective policyholder.

(c) Each long-term care policy or certificate issued in this state after the effective date of this regulation shall provide contingent benefit upon lapse.

(d) The contingent benefit upon lapse shall be triggered every time an insurer increases the premium rates to a level that results in a cumulative

increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth below based on the insured's issue age, and the policy or certificates lapses within 120 days of the due date of the premium so increased. Unless otherwise required, policyholders and certificate holders shall be notified at least 30 days before the due date of the premium reflecting the rate increase.

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

(e) On or before the effective date of a substantial premium increase as defined in subsection (d) of this regulation, the insurer shall perform the following:

(1) Offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(2) offer to convert the coverage to a paid-up status with a shortened benefits period in accordance with the terms of subsection (d) of this regulation. This option may be elected at any time during the 120-day period specified in subsection (d) of this regulation; and

(3) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period specified in subsection (d) of this regulation shall be deemed to be the election of the offer to convert in subsection (d) of this regulation.

(f) Benefits continued as contingent benefit upon lapse shall be as follows:

(1) For purposes of this subsection, attained age rating shall be defined as the schedule of premiums starting from the issue date that increases age at least one percent per year before or at age 50, and at least three percent per year after age 50.

(2) For purposes of this subsection, the contingent-benefit-upon-lapse benefit shall consist of a shortened benefit period providing paid-up long-term care insurance coverage after lapse. The same benefits, with amounts and frequency in effect at the time of the lapse but not increased thereafter, shall be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph (f)(3) of this regulation.

(3) The standard contingent-benefit-upon-lapse credit shall be equal to 100% of the sum of all premiums paid, including the premiums paid before any changes in the benefits. The insurer may offer additional shortened benefits period options, if the benefits for each duration equal or exceed the standard contingent-benefit-upon-lapse credit for that duration. However, the minimum contingent-benefit-upon-lapse credit shall not be less than 30 times the daily nursing home benefit at the time of lapse. In either event, the calculation of the contingent-benefit-upon-lapse credit shall be subject to the limitations of subsection (g) of this regulation.

(4) The contingent benefit upon lapse shall be

effective during the first three years as well as thereafter.

(5) Notwithstanding paragraph (f)(4) for a policy or certificate with attained age rating, the contingent benefit upon lapse shall begin on the earlier of the following:

(A) The end of the 10th year following the policy or certificate issue date; or

(B) the end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(6) Contingent-benefit-upon-lapse credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(g) The benefits paid by the insurer while the policy or certificate is in premium-paying status and in the paid-up status shall not exceed the maximum benefits, which would be payable if the policy or certificate had remained in premium-paying status.

(h) There shall be no difference in the minimum contingent-benefit-upon-lapse benefit as required under this regulation for group and individual policies.

(i) The requirements set forth in this regulation shall be effective on and after January 1, 2003 and shall apply as follows:

(1) Except as provided in paragraph (i)(2), the provisions of this regulation shall apply to any long-term care policy issued in this state on or after January 1, 2003; or

(2) for any certificate issued on or after January 1, 2003, under a group long-term care insurance policy as defined in K.S.A. 40-2227(e) and amendments thereto, which policy was in force at the time this proposed regulation became effective, the provisions of this regulation shall not apply.

(j) Premiums charged for a policy or certificate containing a contingent benefit upon lapse shall be subject to the loss ratio requirements of K.A.R. 40-4-37k treating the policy as a whole.

(k) To determine whether contingent-benefit-upon-lapse provisions are triggered under subsection (d) of this regulation, each replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insurer when the policy was first purchased from the original insurer. (Authorized by K.S.A. 40-103, K.S.A. 40-2228, as amended by L. 2002, ch. 168, sec. 1; implementing K.S.A. 40-2228, as amended by L. 2002, ch. 168, sec. 1; effective Aug. 30, 2002.)

40-4-38. Accident and health insurance policies; limited benefits; notice required. Each limited individual policy of accident and health insurance shall have the words "this is a limited policy—read it carefully" printed on or attached to the face of the policy in not less than 18 point bold face type or in some other manner that distinguishes it from the print otherwise appearing in the policy. For the purposes of this regulation, a limited policy is one that provides long-term care coverage, accident only coverage, specified disease coverage, specific accident coverage, or one that contains unusual exclusions, limitations, reductions or conditions of such a restrictive nature that the benefits under the policy are limited in frequency or in amounts. (Authorized by K.S.A. 40-103 and 40-2404a; implementing K.S.A. 1988 Supp. 40-2404(1); effective May 15, 1989.)

40-4-39. Accident and sickness insurance; specified disease policies; replacement; credit for waiting periods and other time sensitive limitations. (a) This regulation shall apply to individual specified disease policies as defined in K.A.R. 40-4-32 issued by any insurance company, health maintenance organization, or nonprofit hospital and medical service corporation.

(b) Whenever a specified disease policy issued or issued for delivery in this state replaces or is in addition to an existing specified disease policy, the issuing entity shall give credit for the expired portion of any waiting period, elimination period, probationary period or any similar provision.

(c) The credit required by section (b) shall not exceed that earned by the insured under the replaced or previously existing policy and need not be used to place the insured in a more favorable position than would have been the case had a replacement or additional policy not been issued. (Authorized by K.S.A. 40-103 and 40-2404a; implementing K.S.A. 1988 Supp. 40-2404, as amended by L. 1989, Ch. 139, Sec. 1; effective April 16, 1990.)

40-4-40. Accident and sickness insurance; claim forms; acceptance required. (a) As used in this regulation:

(1) "Commissioner" means the commissioner of insurance, state of Kansas.

(2) "Claim form" shall mean any of the forms devised and promulgated by the commissioner pursuant to K.S.A. 1991 Supp. 40-2253.

(3) "Insurer" means insurance companies, health maintenance organizations, mutual nonprofit medical and hospital service corporations, nonprofit dental service corporations, nonprofit optometric service corporations and nonprofit pharmacy service corporations.

(b) Insurers transacting business in this state shall accept and process any claim for benefits designated and submitted on a claim form as defined in subsection (a) of this regulation.

(c) Insurers shall not require health care providers, insureds or other persons to utilize a claim form promulgated by the commissioner if a simplified form will produce the information necessary to process the claim.

(d) This regulation does not prohibit an insurer from requesting additional information from a health care provider when such information is essential to a proper determination of benefit payments.

(e) Claim forms may be modified as necessary to accommodate the transmission and administration of claims by electronic means.

(f) The requirements imposed by this regulation shall take effect and be in force from and after 180 days following the regulation's effective date. (Authorized by K.S.A. 40-103; implementing K.S.A. 1991 Supp. 40-2253; effective Jan. 4, 1993.)

40-4-41. Utilization review organizations; standards. The Kansas insurance department's "policy and procedure to relating to health utilization management standards," dated August 23, 2007, is hereby adopted by reference. (Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001; amended Jan. 12, 2007; amended April 18, 2008.)

40-4-41a. (Authorized by K.S.A. 40-103 and K.S.A. 1994 Supp. 40-22a01, et seq.; implementing K.S.A. 1994 Supp. 40-22a04; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; revoked April 18, 2008.)

40-4-41b. (Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001; amended Jan. 12, 2007; revoked April 18, 2008.)

40-4-41c. (Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended May 16, 1997; amended June 22, 2001; amended Jan. 12, 2007; revoked April 18, 2008.)

40-4-41d. (Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001; amended Jan. 12, 2007; revoked April 18, 2008.)

40-4-41e. (Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001; amended Jan. 12, 2007; revoked April 18, 2008.)

40-4-41f. (Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001; amended Jan. 12, 2007; revoked April 18, 2008.)

40-4-41g. (Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04 and 40-22a11; effective, T-40-4-26-95, April 26, 1995; effective June 12, 1995; amended June 22, 2001; revoked April 18, 2008.)

40-4-41h. (Authorized by K.S.A. 40-103 and K.S.A. 1999 Supp. 40-22a04 and 40-22a11; implementing K.S.A. 1999 Supp. 40-22a04 and 40-22a11; effective June 22, 2001; revoked April 18, 2008.)

40-4-41i. (Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04; effective June 22, 2001; amended Jan. 12, 2007; revoked April 18, 2008.)

40-4-41j. (Authorized by K.S.A. 40-103, 40-22a04, and 40-22a11; implementing K.S.A. 40-22a04 and 40-22a09; effective June 22, 2001; amended Jan. 12, 2007; revoked April 18, 2008.)

40-4-42. Definitions; external review. (a) "Authorized representative" means any of the following:

(1) A person to whom the insured has given express written consent to represent the insured in an external review, unless the request for ex-

ternal review involves either of the following conditions:

(A) A situation exists in which the insured has an emergency medical condition and the time frame for standard external review pursuant to K.A.R. 40-4-42d would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place a person's health in serious jeopardy; or

(B) express written consent cannot be obtained in a timely manner or is impracticable;

(2) a person authorized by law to provide substituted consent for an insured; or

(3) a family member of the insured or the insured's treating health care professional if the insured is unable to provide consent.

(b) "Business day" is a day that is not a Saturday, Sunday, or legal holiday. A legal holiday is either of the following:

(1) Any day designated as a holiday by the congress of the United States or by the Kansas legislature; or

(2) any additional day that is designated by the governor in a particular year, on which state offices are closed in observance of a holiday or a holiday season.

(c) "Certification" means a determination by an insurer or its designee utilization review organization that an admission, availability of care, continued stay, or other health care service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

(d) "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and, for a physician, who holds a current certification by a recognized American medical specialty board in the same or similar specialty that typically manages the medical condition, procedure, or treatment under review.

(e) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by an insurer to determine the necessity and appropriateness of health care services.

(f) "Commissioner" means the commissioner of insurance of the state of Kansas.

(g) "Covered benefits" or "benefits" means those health care services to which an insured is entitled under the terms of a health benefit plan.

(h) "Discharge planning" means the formal process for determining, before discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

(i) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition as defined in L. 1999, Ch. 162, Sec. 6, and amendments thereto.

(j) "External review" means an independent review of adverse decisions by an entity designated as an external review organization as defined in L. 1999, Ch. 162, Sec. 6, and amendments thereto.

(k) "Facility" means an institution providing health care services or a health care setting, including the following:

(1) Hospitals and other licensed inpatient centers;

(2) ambulatory surgical or treatment centers;

(3) skilled nursing centers;

(4) residential treatment centers;

(5) diagnostic, laboratory, and imaging centers; and

(6) rehabilitation and other therapeutic health settings.

(l) "Final adverse decision" means an adverse decision, as defined in L. 1999, Ch. 162, Sec. 6, and amendments thereto, that has been upheld by an insurer, or its designee utilization review organization, at the completion of the insured's internal grievance procedures. When the term "adverse decision" is used in K.A.R. 40-4-42 through 40-4-42g, it shall mean the same as "final adverse decision."

(m) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law.

(n) "Health care provider" or "provider" means a health care professional or a facility.

(o) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(p) "Prospective review" means a utilization review conducted before an admission or a course of treatment.

(q) "Retrospective review" means a utilization review of medical necessity conducted after services have been provided to a patient. This term shall not include the review of a claim that is limited to an evaluation of reimbursement levels, ve-

racity of documentation, accuracy of coding, or adjudication for payment.

(r) "Utilization review" means the evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities as defined in K.S.A. 40-22a01, et seq., and amendments thereto.

(s) "Utilization review organization" means any entity that conducts a utilization review and determines the certification of an admission, extension of stay, or other health care service, as defined in K.S.A. 40-22a01, et seq., and amendments thereto.

This regulation shall take effect on and after January 1, 2000. (Authorized by K.S.A. 40-103 and L. 1999, Ch. 162, § 9; implementing L. 1999, Ch. 162, §§ 6-9; effective Jan. 7, 2000.)

40-4-42a. Notice requirements of adverse decisions. (a) A written notification of an adverse decision shall be printed in clear, legible type and in at least 12-point type.

(b) The notice of adverse decision shall explain the principal reason for the adverse decision in language easily understood by a person with an eighth-grade reading level. An insurer may meet this requirement by omitting medical terminology that describes an insured's medical condition. The notice shall include the proper names of all impacted parties, telephone numbers, and addresses.

(c) The notice of adverse decision shall explain how an insured, as defined in L. 1999, Ch. 162, Sec. 6, and amendments thereto, can initiate an external review with the commissioner. If an insured is eligible for an expedited review due to an emergency medical condition as defined in L. 1999, Ch. 162, Sec. 6, and amendments thereto, then the notice shall explain how an insured can initiate an expedited review.

(d) The notice shall explain that an insured may file for an external review with the commissioner within 90 days of receipt of a final adverse decision. The notice shall also list the Kansas insurance department's toll-free number.

(e) The notice of adverse decision shall describe how the insured can request a written statement of the clinical rationale and clinical review criteria used to make the adverse decision.

This regulation shall take effect on and after January 1, 2000. (Authorized by K.S.A. 40-103 and L. 1999, Ch. 162, § 9; implementing L. 1999, Ch. 162, §§ 6-9; effective Jan. 7, 2000.)

40-4-42b. Preliminary determination by commissioner. (a) Within 10 business days after receiving the written request for external review and all necessary information, a preliminary determination shall be completed by the commissioner. The insured, the treating physician or insured's authorized representative or health care provider acting on behalf of the insured, and the insurer or health insurance plan shall be notified by the commissioner in writing of any of the following:

(1) If the request for external review is complete and has been accepted;

(2) If the request for external review is not complete; or

(3) if the request for external review is not accepted.

(b) Preliminary determination by the commissioner shall be to determine the following:

(1) If the individual is or was an insured in the insurance plan at the time the health care service was requested or, in the case of a retrospective review, was an insured in the insurance plan at the time the health care service was provided;

(2) if the health care service that is the subject for the adverse decision reasonably appears to be a covered service under the insured's insurance plan;

(3) if the insured has exhausted all available internal review procedures provided by the health insurance plan or insurer, unless the insured has an emergency medical condition as defined in L. 1999, Ch. 162, Sec. 6, and amendments thereto, in which case an expedited procedure is used;

(4) if the insured has received an adverse decision as defined in L. 1999, Ch. 162, Sec. 6(a), and amendments thereto, and K.A.R. 40-4-42(l);

(5) if the insured has not exhausted all internal review procedures, but is entitled to external review pursuant to L. 1999, Ch. 162, Sec. 7, and amendments thereto; and

(6) if the insured has provided all the information and forms required by the commissioner that are necessary to process and external review request.

(c) If the request for external review is accepted, the following steps shall be taken by the commissioner:

(1) Assign an independent review organization to conduct the external review that has been approved pursuant to L. 1999, Ch. 162, Secs. 6 and 8, and amendments thereto, and K.A.R. 40-4-42e; and

(2) notify the insured, the treating physician or health care provider acting on behalf of the insured or the insured's authorized representative, and the insurer or health insurance plan in writing that the request has been accepted for external review and provide the name, address, and telephone number of the external review organization who has been assigned to conduct the external review.

(d) If the request for external review is not complete, the insured or the insured's authorized representative shall be informed by the commissioner of the information or materials needed to make the request complete.

(e) If the request for external review is not accepted, the insured, the treating physician or health care provider acting on behalf of the insured or the insured's authorized representative, and the insurer or health insurance plan shall be informed by the commissioner, in writing, of the reasons for its nonacceptance.

This regulation shall take effect on and after January 1, 2000. (Authorized by K.S.A. 40-103 and L. 1999, Ch. 162, § 9; implementing L. 1999, Ch. 162, §§ 6-9; effective Jan. 7, 2000.)

40-4-42c. Standard external review procedures. (a) At the time a request for external review is accepted pursuant to K.A.R. 40-4-42b, an external review organization that has been approved pursuant to L. 1999, Ch. 162, Sec. 8, and amendments thereto, shall be assigned by the commissioner to conduct the external review.

(b) In reaching a decision, the assigned external review organization shall not be bound by any decisions or conclusions reached during the insurer's utilization review process as set forth in K.S.A. 40-22a01 and L. 1999, Ch. 162, Secs. 6 through 9, and amendments thereto, or the insurer's internal grievance process.

(c) Within seven business days after the date of receipt of the notice provided in K.A.R. 40-4-42b, the insurer or its designee utilization review organization, or the insured or the insured's authorized representative may provide the assigned external review organization with additional documents and information that they wish the assigned external review organization to consider in making its decision.

(d) Failure by the insurer to provide the documents and information within the time specified in L. 1999, Ch. 162, Sec. 7(g), shall not delay the conduct of the external review.

(e)(1) The assigned external review organization shall review all of the information and documents received pursuant to subsection (c) of this regulation and any other information submitted in writing by the insured or the insured's authorized representative pursuant to K.A.R. 40-4-42b.

(2) Upon receipt of any information submitted by the insured or the insured's authorized representative pursuant to K.A.R. 40-4-42b, the information shall be forwarded to the external review organization and the insurer.

(f)(1) Upon receipt of the information required to be forwarded pursuant to paragraph (e)(2) of this regulation, the insurer may reconsider its adverse decision that is the subject of the external review.

(2) Reconsideration by the insurer of its adverse decision as provided in paragraph (f)(1) of this regulation shall not delay or terminate the external review.

(3) The external review may be terminated only if the insurer reconsiders its adverse decision and decides to provide coverage or payment for the health care service that is the subject of the adverse decision.

(4)(A) Immediately upon making the decision to reverse its adverse decision as provided in paragraph (f)(3) of this regulation, the insurer shall notify, in writing, the insured or the insured's authorized representative, the assigned external review organization, and the commissioner of the insurer's decision.

(B) The assigned external review organization shall terminate the external review upon receipt of the notice from the insurer sent pursuant to paragraph (f)(4)(A) of this regulation.

(g) In addition to the documents and information provided pursuant to subsection (c) of this regulation, the assigned external review organization, to the extent that the documents or information is available, shall consider the following in reaching a decision:

(1) The insured's pertinent medical records;

(2) the attending health care professional's recommendation;

(3) consulting reports from appropriate health care professionals and other documents submitted by the insurer, the insured, the insured's authorized representative, or the insured's treating provider;

(4) the terms of coverage under the insured's insurance plan with the insurer, to ensure that the external review organization's decision is not con-

trary to the terms of coverage under the insured's insurance plan with the insurer;

(5) the most appropriate practice guidelines, including generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government and national or professional medical societies, boards, and associations; and

(6) any applicable clinical review criteria developed and used by the insurer or its designee utilization review organization.

(h) Within 30 business days after the date of receipt of the request for external review, the assigned external review organization shall provide written notice of its decision to uphold or reverse the adverse decision to the following:

(1) The insured or the insured's authorized representative;

(2) the insurer; and

(3) the commissioner.

(i) The external review organization shall include the following in the notice sent pursuant to subsection (h) of this regulation:

(1) A general description of the reason for the request for external review;

(2) the date the external review organization received the assignment from the commissioner to conduct the external review;

(3) the date the external review was conducted;

(4) the date of the external review organization's decision;

(5) the principal reason or reasons for the external review organization's decision;

(6) the rationale for the external review organization's decision; and

(7) references, as needed, to the evidence or documentation, including the practice guidelines that the external review organization considered in reaching its decision.

This regulation shall take effect on and after January 1, 2000. (Authorized by K.S.A. 40-103 and L. 1999, Ch. 162, § 9; implementing L. 1999, Ch. 162, §§ 6-9; effective Jan. 7, 2000.)

40-4-42d. Expedited external review. (a) If the insured has an emergency medical condition, as defined in L. 1999, Ch. 162, Sec. 6, and amendments thereto, and receives an adverse decision involving that medical condition, the insured or the insured's authorized representative may make a written request for an expedited review with the commissioner at the time the insured receives the adverse decision.

(b) At the time the commissioner receives a request for an expedited external review, a preliminary determination shall immediately be completed by the commissioner to determine the following:

(1) If the individual is or was an insured in the insurance plan at the time the health care service was requested; and

(2) if the health care service that is the subject of the adverse decision reasonably appears to be a covered service under the insured's health insurance plan.

(c) At the time the commissioner completes the preliminary determination as provided in subsection (b) of this regulation, the following actions shall immediately be taken by the commissioner:

(1) Assign an external review organization that has been approved pursuant to L. 1999, Ch. 162, Secs. 6 and 8, and amendments thereto, to conduct the review and to make a decision to uphold or reverse the adverse decision; and

(2) send a copy of the request for the review to the insurer or health plan that made the adverse decision that is the subject of the request and notify the insured, the treating physician or health care provider, and the insurer or health plan of the name, address, and telephone number of the external review organization assigned to conduct the expedited external review.

(d) In reaching a decision, the assigned external review organization shall not be bound by any decision or conclusions reached during the insurer's utilization review process as set forth in K.S.A. 40-22a01 and L. 1999, Ch. 162, Secs. 6 through 9, and amendments thereto, or the insurer's internal grievance process.

(e) At the time the insurer receives the notice pursuant to paragraph (c)(2), the insurer or its designee utilization review organization shall provide or transmit all necessary documents and information that were considered in making the adverse decision to the assigned external review organization by electronic means, by telephone or facsimile, or by any other available expeditious method by 5:00 p.m. central standard time of the next business day after receiving notice pursuant to paragraph (c)(2) of this regulation.

(f) In addition to the documents and information provided or transmitted pursuant to subsection (e) of this regulation and to the extent that the information or documents are available, the assigned external review organization shall consider the following in reaching a decision:

(1) The insured's pertinent medical records;

(2) the attending health care professional's recommendation;

(3) consulting reports from appropriate health care professionals and any other documents submitted by the insurer, the insured, the insured's authorized representative, or the insured's treating provider;

(4) the terms of the coverage under the insured's insurance plan with the insurer, to ensure that the external review organization's decision is not contrary to the terms of coverage under the insured's health benefit plan with the insurer;

(5) the most appropriate practice guidelines, including generally accepted practice guidelines, evidence-based practice guidelines, and any other practice guidelines developed by the federal government and national or professional medical societies, boards, and associations; and

(6) any applicable clinical review criteria developed and used by the insurer or its designee utilization in making adverse decisions.

(g)(1) As expeditiously as the insured's medical condition or circumstances require, but not more than seven business days after the date of receipt of the request for an expedited external review, the assigned external review organization shall perform the following:

(A) Make a decision to uphold or reverse the adverse decision; and

(B) notify the insured or the insured's authorized representative, the insurer, and the commissioner of the decision.

(2) If the notice provided pursuant to paragraph (g)(1) of this regulation was not in writing, within two days after the date of providing that notice, the assigned external review organization shall perform the following:

(A) Provide written confirmation of the decision to the insured or the insured's authorized representative, the insurer, and the commissioner; and

(B) include the information set forth in K.A.R. 40-4-42c(h).

(h) An expedited external review shall not be provided for retrospective adverse decisions.

This regulation shall take effect on and after January 1, 2000. (Authorized by K.S.A. 40-103 and L. 1999, Ch. 162, § 9; implementing L. 1999, Ch. 162, §§ 6-9; effective Jan. 7, 2000.)

40-4-42e. Minimum qualifications for external review organizations. (a) To be approved under K.A.R. 40-4-42e and L. 1999, Ch. 162, Secs. 6 through 9, and amendments thereto, to conduct external reviews, an external review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in K.A.R. 40-4-42c and K.A.R. 40-4-42d and that include at minimum:

(1) A quality assurance mechanism in place that meets the following criteria:

(A) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(B) ensures the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the external review organization and suitable matching of reviewers to specific cases;

(C) ensures the confidentiality of medical and treatment records and clinical review criteria; and

(D) ensures that any person employed by or under contract with the external review organization adheres to requirements of L. 1999, Ch. 162, Secs. 6 through 9, and amendments thereto, and K.A.R. 40-4-42 through 40-4-42g;

(2) a toll-free telephone service to receive, on a 24 hours per day, seven days per week basis, information related to external review that is capable of accepting, recording, or providing appropriate instructions to incoming telephone callers during other than normal business hours; and

(3) an agreement to maintain and provide to the commissioner the information set out in K.A.R. 40-4-42g.

(b) All clinical peer reviewers assigned by an external review organization to conduct external reviews shall be physicians or other appropriate health care providers who meet the following minimum qualifications:

(1) Are qualified and credentialed in the treatment of the insured's medical condition that is the subject of the external review;

(2) are knowledgeable about the recommended health care service or treatment through actual or recent clinical experience that may be based on the following:

(A) The actual treatment of patients with the same or similar medical condition as that of the insured; and

(B) the period of time that has elapsed between the clinical experience and the present;

(3) hold a nonrestricted license in a state of the

United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

(4) have no history of disciplinary actions or sanctions, including loss of staff privileges or any participation restriction that has been taken or is pending by any hospital, governmental agency or unit, or regulatory body, that raises a substantial question as to the clinical peer reviewer's physical, mental, or professional competence, or moral character.

(c) In addition to the requirements set forth in subsection (a) of this regulation, an external review organization shall not own or control, be a subsidiary of, or in any way be owned or controlled by, or exercise control, with any of the following:

(1) An insurance plan;

(2) a national, state, or local trade association of health insurance plans; or

(3) a national, state, or local trade association of health care providers.

(d) In addition to the requirements set forth in subsections (a), (b), and (c) of this regulation, to be approved pursuant to L. 1999, Ch. 162, Sec. 8, and amendments thereto, to conduct an external review of a specified case, neither the external review organization selected to conduct the external review nor any clinical peer review assigned by the external organization to conduct the external review may have a material professional, familial, or financial conflict of interest with any of the following:

(1) The insurer that is the subject of the external review;

(2) the insured whose treatment is the subject of the external review or the insured's authorized representative;

(3) any officer, director, or management employee of the insurer that is the subject of the external review;

(4) the health care provider, the health care provider's medical group, or the independent practice association recommending the health care service or treatment that is the subject of the external review;

(5) the facility at which the recommended health care service or treatment would be provided; or

(6) the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended for the insured whose treatment is the subject of the external review.

This regulation shall take effect on and after January 1, 2000. (Authorized by K.S.A. 40-103 and L. 1999, Ch. 162, § 9; implementing L. 1999, Ch. 162, §§ 6-9; effective Jan. 7, 2000.)

40-4-42f. External review reporting requirements. (a) An external review organization assigned pursuant to K.A.R. 40-4-42c and 40-4-42d to conduct an external review shall maintain written records in the aggregate and by health carrier on all requests for external review for which it conducted an external review during a calendar year and submit a report to the commissioner as required in paragraph (b)(1) of this regulation.

(b)(1) Each external review organization required to maintain written records on all requests for external review pursuant to subsection (a) of this regulation for which it was assigned to conduct an external review shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(2) The report shall include the following, at a minimum, in the aggregate and for each insurer:

(A) The total number of requests for external review;

(B) the number of requests for external review resolved and, of those resolved, the number resolved upholding the adverse decision and number resolved reversing the adverse decision;

(C) the average length of time for resolution;

(D) the number of external reviews pursuant to K.A.R. 40-4-42c(e) that were terminated as the result of a reconsideration by the insurer of its adverse decision after the receipt of additional information from the insured or the insured's authorized representative; and

(E) any other information that the commissioner may request or require.

(c) The external review organization shall retain the written records required pursuant to this regulation for at least five years after the final decision has been issued.

This regulation shall take effect on and after January 1, 2000. (Authorized by K.S.A. 40-103 and L. 1999, Ch. 162, § 9; implementing L. 1999, Ch. 162, §§ 6-9; effective Jan. 7, 2000.)

40-4-42g. Exhaustion of internal review process. (a)(1) Except as provided in subsection (b) of this regulation, a request for external review pursuant to K.A.R. 40-4-42c and K.A.R. 40-4-42d

shall not be made until the insured has exhausted the insurer's internal review process.

(2) An insured shall be considered to have exhausted the insurer's internal review process for the purposes of this regulation if the insured or the insured's authorized representative meets either of the following criteria:

(A) Has filed a request for internal review and received an adverse decision pursuant to the internal review procedures provided by the health insurance plan or insurer; or

(B) except to the extent that the insured or the insured's authorized representative requested or agreed to a delay, has not received a final decision from the insurer within 60 days of seeking the internal review.

(b)(1) A request for external review of an adverse decision may be made before the insured has exhausted the insurer's or health insurance plan's internal grievance procedures, if either of the following circumstances applies:

(A) The insured has a emergency medical condition as defined in L. 1999, Ch. 162, Sec. 6, and amendments thereto.

(B) The insurer agrees to waive the exhaustion requirement.

(2) Notwithstanding paragraph (b)(1), an insured or the insured's authorized representative shall not make a request for an external review of an adverse decision involving a retrospective review decision made pursuant to K.S.A. 40-22a01 and L. 1999, Ch. 162, Secs. 6 through 9, and amendments thereto, until the insured has exhausted the insurer's internal review process.

(c) If the requirement to exhaust the insurer's internal review process is waived under paragraph (b)(1)(B), the insured or the insured's authorized representative may request a standard external review pursuant to K.A.R. 40-4-42d.

This regulation shall take effect on and after January 1, 2000. (Authorized by K.S.A. 40-103 and L. 1999, Ch. 162, § 9; implementing L. 1999, Ch. 162, §§ 6-9; effective Jan. 7, 2000.)

Article 5.—CREDIT INSURANCE

40-5-1 and 40-5-2. (Authorized by K.S.A. 16-507, 16-413, 40-103; effective Jan. 1, 1966; revoked Jan. 1, 1974.)

40-5-3. (Authorized by K.S.A. 16-413, 16-507, 40-103, 40-234, K.S.A. 1965 Supp. 40-433; effective Jan. 1, 1966; revoked Jan. 1, 1974.)

40-5-4. (Authorized by K.S.A. 40-103, K.S.A. 1969 Supp. 16-413, 16-507, 40-216, 40-434; effective Jan. 1, 1966; amended Jan. 1, 1970; revoked Jan. 1, 1974.)

40-5-5. (Authorized by K.S.A. 40-103, 40-415; effective Jan. 1, 1966; revoked Jan. 1, 1974.)

40-5-6. Credit insurance; property and liability; insurance sold in connection with the uniform consumer credit code; types. The following types of insurance shall be authorized for sale:

(a) For motor vehicles:

(1) Fire, theft, windstorm coverage; or comprehensive coverage, including fire, theft and windstorm;

(2) collision coverage with a deductible of $50 or more; and

(3) bodily injury and property damage liability insurance in accordance with K.S.A. 16a-4-303.

(b) For real property and tangible personal property, other than motor vehicles:

(1) Fire, including lightning coverage and extended coverage. Extended coverage shall be limited to perils of windstorm, hail, explosion, riot, riot attending a strike, civil commotion, aircraft, vehicles, and smoke;

(2) other perils as set out in the extended coverage endorsement approved by the Kansas insurance commissioner for use by a fire or multiple line insurance company; and

(3) bodily injury and property damage liability insurance. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-301, 16a-4-303; effective Jan. 1, 1966; amended Jan. 1, 1969; amended Jan. 1, 1974; amended May 1, 1986.)

40-5-7. Credit insurance; property and liability; insurance sold in connection with Kansas uniform consumer credit code; requirements. (a) Credit property and liability insurance sold in connection with the Kansas uniform consumer credit code shall be written by an insurance company authorized to do business in the state of Kansas.

(b) If insurance covering the purchaser's interest in goods is purchased by the mortgagee or conditional sale vendor, the mortgagee or conditional sale vendor shall, within 30 days after the execution of the retail installment contract, send or cause to be sent to the purchaser a policy, or policies, or certificate, or certificates of insurance, written by an insurance company authorized to do

business in this state. The contract shall clearly set forth the amount of the premium, the kind or kinds of insurance, the coverages and terms, exceptions, limitations, restrictions and conditions of the contract or contracts.

(c) Each individual policy or certificate of insurance covering the interest of both purchaser and mortgagee or conditional sale vendor shall be issued in the name of the purchaser where the premium is paid either directly or indirectly by the purchaser. The interest of a mortgagee or conditional sale vendor shall be set forth clearly in each policy and a mortgagee or conditional sale vendor shall participate in loss payments only as its interest may appear. In the event of cancellation or premium adjustment, unearned premium shall be returned:

(1) Directly to the purchasers; or

(2) to the mortgagee or conditional sale vendor where the insurer has notice of assignment of unearned premium by the purchaser to the mortgagee or conditional sale vendor.

(d) Each insurance contract sold in connection with a loan subject to the Kansas uniform consumer credit code shall be written in accordance with the rates, rules, and forms filed with and approved by the commissioner of insurance.

(e) Any differential in premium rates shall not be charged based on distinction between financed and nonfinanced property.

(f) A creditor may not contract for or receive a separate charge for insurance against loss or damage of property unless:

(1) The insurance covers a substantial risk of loss or damage to property related to the credit transaction;

(2) the amount, terms and conditions of the insurance are reasonable in relation to the character and value of the property insured or to be insured;

(3) the term of insurance is reasonable in relation to the terms of credit;

(4) the property is purchased pursuant to a credit card or an open-end credit transaction; or

(5) the amount financed exclusive of charges for insurance is $300 or more, and the value of the property is $300 or more. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A 16a-4-301; effective Jan. 1, 1966; amended Jan. 1, 1974; amended May 1, 1975; amended May 1, 1979; amended May 1, 1986.)

40-5-8. Same; vendors single interest. Insurers are prohibited from selling to purchasers, or mortgagors of automobile vendors, single interest coverages including loss by wrongful conversion, embezzlement, or secretion or any other vendors single interest coverage in which a purchaser or mortgagor has no insurable interest. When a vendor single interest coverage is included in an insurance policy covering the interest of a purchaser or mortgagor, the insurance contract shall clearly indicate that the premium for the vendor single interest coverage has been charged to the vendor or mortgagee. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-202; effective Jan. 1, 1966; amended Jan. 1, 1974; amended May 1, 1986.)

40-5-9. Credit insurance; fire, casualty and allied lines; mortgagors and mortgagees; conditional sales vendors; and vendors; requirements. (a) All insurers writing insurance specified in Kansas Statutes Annotated, chapter 40, articles 9, 10, 11, 12, and 16 shall be prohibited from issuing policies covering the interests of a mortgagor and a mortgagee or conditional sales vendor where the mortgagee or conditional sales vendor is, in any manner, the named insured on the policy.

(b) The policy shall be issued only in the name of the mortgagor and mortgagee or conditional sales vendor's interest in the policy shall be limited to participation in recoveries under the perils insured as its interest may appear.

(c) The mortgagee or conditional sales vendor shall not be entitled to the return of unearned premium unless the insurer has notice of assignment of unearned premium by the mortgagor to the mortgagee or conditional sales vendor. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-301; effective Jan. 1, 1966; amended Jan. 1, 1974; amended May 1, 1979; amended May 1, 1986.)

40-5-10. Credit insurance; fire and extended coverage; issuance for single indivisible premium; requirements. Fire and extended coverage insurance permitted by Kansas administrative regulation 40-5-6 may be issued for a single indivisible premium subject to the following requirements:

(a) The location of the property insured shall be extended by the policy provisions to insure the property at any location within the continental limits of the United States.

(b) The maximum amount of insurance permitted under this policy shall not exceed $10,000.

(c) The insurer shall be required to obtain a statement from the insured that indicates all of the following:

(1) No other valid and collectible insurance on the insured property exists.

(2) The purchase of insurance from any insurer or agent was the choice of the insured.

(3) The purchase of insurance in connection with the credit transaction is entirely voluntary and not a prerequisite to the extension of credit.

(d) The creditor shall not refuse or decline the insurance provided by the consumer except for reasonable cause. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-301, 16a-4-111; effective Jan. 1, 1966; amended Jan. 1, 1974; amended May 1, 1979; amended May 1, 1986; amended May 1, 1987; amended Oct. 30, 1998.)

40-5-11. (Authorized by K.S.A. 40-103, K.S.A. 1969 Supp. 16-211; effective, E-69-20, Sept. 1, 1969; effective Jan. 1, 1970; revoked Jan. 1, 1974.)

40-5-12. Consumer credit insurance; termination of coverage; prohibited contractual provisions. (a) A policy or certificate of consumer credit insurance as defined in K.S.A. 16a-4-103, that may be issued, delivered, renewed or continued within or outside this state covering residents of this state, shall not contain provisions which permit coverage to be terminated by the insurer with respect to any policyholder, certificate holder or other insured person unless:

(1) The policy or certificate is formally and specifically terminated;

(2) the insured and any affected certificate holder is provided not less than ten days written notice of termination; and

(3) any unearned premium is returned to the borrower or credited to the account of the consumer as required by K.S.A. 16a-4-108.

(b) The restrictions imposed by section (a) of this regulation shall not apply with respect to transactions permitted or required by K.S.A. 16a-4-108. (Authorized by K.S.A. 40-103; 16a-4-112; implementing K.S.A. 16a-4-203; effective Nov. 29, 1993.)

40-5-13 to 40-5-100. Reserved.

40-5-101. (Authorized by K.S.A. 16a-4-112; effective Jan. 1, 1974; revoked May 1, 1979.)

40-5-102. Consumer credit insurance; definitions. (a) "Credit life insurance" means insurance on the life of a consumer pursuant to or in connection with a consumer credit transaction.

(b) "Credit accident and health insurance" means insurance, written in connection with a consumer credit transaction, to provide benefits in the event of disability of a consumer.

(c) "Claims incurred" means claims actually paid during the year, appropriately adjusted for the yearly change in claim reserves, including reserves for reported claims in process of settlement and claims incurred but not reported.

(d) "Claims" means benefits payable on death or disability excluding loss adjustment expense, claims settlement costs, or other additions of any kind.

(e) "Premiums earned" means the total gross premiums which become due to the insurance company, without reduction of any kind, except the premiums refunded or adjusted on account of termination of coverage, and appropriately adjusted for changes in gross unearned premiums in force upon a pro rata basis or a "sum of the digits" basis consistent with K.A.R. 40-5-108(a).

(f) "Commissioner" means the commissioner of insurance of the state of Kansas. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-101 through 16a-4-203; effective Jan. 1, 1974; amended May 1, 1979; amended May 1, 1983; amended May 1, 1986.)

40-5-103. Same; rights and treatment of consumers. (a) Multiple plans of insurance. If a creditor makes available to consumers more than one plan of credit life insurance, or more than one plan of credit accident and health insurance, all appropriate consumers shall be informed of all available plans.

(b) Substitution. When a creditor requires credit life insurance, credit accident and health insurance, or both, as additional security for an indebtedness, the debtor shall be given the option of furnishing the required amount of insurance through existing policies of insurance, or procuring and furnishing the required coverage through any insurer authorized to transact insurance business in this state. In such a case, the debtor shall be informed by the creditor of the right to provide alternative coverage before the transaction is completed.

(c) Evidence of coverage.

(1) All consumer credit insurance shall be evidenced by an individual policy, or in the case of

group insurance, by a certificate of insurance. The individual policy or certificate of insurance shall be delivered to the consumer in accordance with K.S.A. 16a-4-105.

(2) Policy provisions.

(A) Each insurance policy or certificate used in connection with a loan or credit transaction shall contain:

(i) the name and home office address of the insurer;

(ii) the name or names of the debtor;

(iii) the premium, or amount of payment by the debtor, if any, for credit life insurance and for credit accident and health insurance;

(iv) a statement specifying when the insurance of the debtor will become effective and its termination conditions, or the month, day, and year the insurance begins and terminates;

(v) any exceptions, limitations, or restrictions; and

(vi) a statement that the life of the debtor is insured under the policy and that any death benefit paid by reason of death of the debtor shall be applied first to reduce or extinguish the indebtedness.

(B) In addition to the requirements of paragraph (A), each insurance policy issued in connection with a credit transaction or loan shall set forth the kind or kinds of insurance included, the coverages, and all the terms, exceptions, limitations, restrictions, and conditions of the contract or contracts of insurance. Certificates shall contain all provisions of the master policy applicable to the debtor.

(C) The requirements of paragraph (2) are in addition to other requirements imposed by law concerning policy forms and their approval.

(3) Settlement of claims. Separate credit life insurance payments shall be made to the creditor, beneficiary, and to the named second beneficiary, if any, as their interests may appear. If the policy contains no provision for the designation of a second beneficiary, the insurance shall go to the estate of the insured. Each payment made to the creditor shall reduce the indebtedness.

(d) Termination of coverage.

(1) If a debtor is covered by a group insurance policy on which a single premium is charged for insurance, the policy shall provide that the group policy may terminate only with respect to debtors who would otherwise become eligible for coverage after the date of termination, and that insurance coverage with respect to any debtor insured under the policy shall be continued for the entire period for which a single charge has been made, subject to subsections (g) and (h).

(2) If a debtor covered by a group credit insurance policy is charged for insurance on a monthly outstanding balance basis, the policy shall provide that, if the policy is terminated, the insured debtor shall be notified that coverage will terminate not less than 15 days after mailing of the notice. If notice is not given to each insured debtor, coverage shall continue for 30 days from the date of notice to the policyholder, except where replacement of the coverage by the same or another insurer in the same or greater amount takes place without lapse of coverage. The notice to insured debtors required in this paragraph shall be given by the insurer, or at the option of the insurer, by the creditor.

(e) Interest on premiums. If the creditor adds identifiable insurance charges or premiums for consumer credit insurance to the indebtedness, and any direct or indirect finance, carrying, credit, or service charge is made to the consumer on the insurance charges or premiums, the creditor shall remit and the insurer shall collect on a single premium basis only.

(f) Renewal or refinancing of indebtedness. If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall be terminated before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited to the debtor as provided in K.A.R. 40-5-108. In any renewal or refinancing of indebtedness, the effective date of the coverage of any policy provision shall be the first date on which the debtor became insured under the policy covering the indebtedness which was renewed or refinanced, at least in the amount of the indebtedness outstanding at the time of renewal and refinancing of the debt.

(g) Voluntary prepayment of indebtedness. If a debtor prepays indebtedness for a reason other than death or a lump sum disability payment:

(1) Any credit life insurance covering an indebtedness shall be terminated and an appropriate refund shall be paid or credited to the debtor by the creditor at the time of prepayment pursuant to K.A.R. 40-5-108; and

(2) any credit accident and health insurance covering an indebtedness shall be terminated and an appropriate refund shall be paid or credited to

the debtor by the creditor at the time of prepayment. If the indebtedness is prepaid by the debtor during any period of disability for which benefits are payable, the disability coverage shall continue in force and the insurer shall make periodic payments directly to the debtor until the disability no longer exists or until the end of the term of insurance, whichever occurs first.

(h) Involuntary prepayment of indebtedness. If an indebtedness is prepaid by the proceeds of a credit life insurance policy covering the debtor or by a lump sum payment of a disability claim under a credit accident and health insurance policy covering the debtor, the insurer shall ensure that the following refunds are made by the creditor at the time of prepayment:

(1) In case of prepayment by the proceeds of a credit life insurance policy, an appropriate refund under the credit accident and health insurance coverage; and

(2) in the case of prepayment by a lump sum disability claim, an appropriate refund under the credit life insurance coverage. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-101 through 16a-4-203; effective Jan. 1, 1974; amended May 1, 1979; amended May 1, 1986.)

40-5-104. Same; coverage without separate charge. (a) If no separate charge is made to the consumer for consumer credit insurance, the consumer shall be charged a specific amount for insurance if an identifiable charge for insurance is disclosed in the credit or other instrument furnished the consumer setting out the financial elements of the credit transactions, or if there is a differential in the finance charge (as defined in section 16a-1-301(19)) made to consumers in like circumstances, except for their insured or non-insured status.

(b) The rate standards set out in K.A.R. 40-5-107 shall apply to the premiums for consumer credit insurance. The insurer issuing the coverage must obtain form and rate approval by the commissioner. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-101 through 16a-4-203; effective Jan. 1, 1974; amended May 1, 1986.)

40-5-105. Same; filing requirements. (a) Each policy form, certificate of insurance, notice of proposed insurance, application for insurance, endorsement, and rider to be delivered or issued for delivery in this state and the schedule of premium rates or charges pertaining thereto shall be filed with the commissioner as required by K.S.A. 16a-4-203 (UCCC), including those approved prior to the effective date of this regulation.

(b) Each filing shall be accompanied by supporting information which establishes that the rates meet the standards set out in K.A.R. 40-5-107 or are the actuarial equivalent.

(c) When forms providing benefits as described in K.A.R. 40-5-107 are filed at or below the rates described, supporting information shall not be submitted. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-101 through 16a-4-203; effective Jan. 1, 1974; amended May 1, 1986.)

40-5-106. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-101 through 16a-4-203; effective Jan. 1, 1974; amended May 1, 1979; amended May 1, 1986; revoked Aug. 3, 2001.)

40-5-107. Same; credit insurance rates and forms. (a) The basic test of the reasonableness of the relation of benefits to the premium charges shall be an anticipated loss ratio of "claims incurred" to "premiums earned" of not less than 50 percent. Due consideration shall be given to a reasonable allowance for expenses.

(b) Benefits shall not be reasonable in relation to the premium charged if the premiums or premium rates filed with the commissioner exceed the following, or actuarially equivalent, rates:

(1) Credit life insurance.

(A) For decreasing term life insurance the rate shall not exceed $.65 per $100 insurance per annum;

(B) for joint life insurance the rate shall not exceed one and two-thirds of the appropriate single life rate;

(C) for level term life insurance the rate shall not exceed $1.20 per $100 insurance per annum;

(D) for monthly outstanding balance insurance the rate shall not exceed $1.00 per month per $1,000 of insurance; and

(E) The rates shall be presumed reasonable only if the policies contain:

(i) No exceptions, limitations or exclusions, except for suicide, during the first two years; and

(ii) no age restriction or only age restrictions making ineligible for coverage debtors 65 years or over at the time the indebtedness is incurred, or debtors who have attained age 66 years or over on the maturity date of the indebtedness.

(2) Credit accident and health insurance.

(A) For credit accident and health insurance the following single premium rates per $100 initial insured indebtedness:

	NONRETROACTIVE BASIS	
Number of months in which indebtedness is repayable	14 day elimination period	30 day elimination period
6 or less	1.00	.40
12	1.40	.80
24	2.20	1.60
36	3.00	2.40
48	3.50	2.90
60	3.90	3.30
	RETROACTIVE BASIS	
	14 day elimination period	30 day elimination period
6 or less	1.80	1.30
12	2.20	1.70
24	3.00	2.50
36	3.80	3.30
48	4.30	3.80
60	4.70	4.20

(B) Rates for policies of credit accident and health insurance, the premiums for which are paid other than on a single premium basis, for benefits on a basis different than as provided in (C) below, or for different monthly durations than illustrated, shall be actuarially consistent with the rates specified above.

(C) The premium rates specified shall be for policies which contain no exclusion for pre-existing conditions except for those conditions which manifest themselves to the insured by requiring medical diagnosis or treatment, or would cause a reasonably prudent person to seek medical diagnosis or treatment within six months preceding the effective date of the coverage as to the insured debtor, and which cause loss within the six months following effective date of coverage. Disabilities thereafter resulting from the condition shall be covered.

(c) Each contract to which the foregoing rules apply may contain provisions excluding or restricting coverage in the event of total disability resulting from pregnancy, intentionally self-inflicted injuries, flight in nonscheduled aircraft, or war. The policies may contain the same age limitation on eligibility as set forth for credit life policies.

(d) Each new policy or certificate of consumer credit insurance issued after the effective date of this regulation shall not be at a rate exceeding any provision of this regulation.

(e) Each insurer may receive approval of a higher premium rate or schedule of rates to be used in connection with a particular policy form providing insurance on the debtors of a creditor or a class or classes of debtors if the insurer demonstrates, to the satisfaction of the commissioner, that the mortality or morbidity experience which may reasonably be anticipated shall develop a loss ratio in excess of 60 percent when the rate standards in K.A.R. 40-5-107 are used.

(f) On the basis of mortality or morbidity experience reported under K.A.R. 40-5-109, the premium rates may be continued, allowed to be increased, or required to be decreased. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-203; effective Jan. 1, 1974; amended May 1, 1979; amended May 1, 1986; amended May 1, 1988.)

40-5-108. Same; refunds. (a) Formulas for computing refunds of credit insurance premiums shall be acceptable to the commissioner for coverage as follows:

(1) Pro rata method. The pro rata unearned gross premium method for level term credit life insurance, credit accident and health insurance where the insured is covered for a constant maximum indemnity for a given period of time, after which the maximum indemnity begins to decrease in even amounts per month, and for credit insurance coverages under which premiums are collected from the consumer on a basis other than the single premium basis.

(2) Sum of the digits method. The "rule of 78" or "sum of the digits" unearned premium method of coverages other than those included in paragraph (1).

(b) At the option of the insurer but consistent with subsection (a):

(1) Any charge for credit insurance may not be made for the first 15 days of a loan month and a full month may be charged for 16 days or more of a loan month; or

(2) a refund may be made on a pro rata basis for each day within the loan month.

(c) The requirements of K.S.A. 16a-4-108 that refund formulas be filed with the commissioner shall be considered fulfilled if the refund formulas shall be set forth in the individual policy or group certificate filed with the commissioner. If the appropriate refund formula is the "sum of the digits" formula, commonly known as the "rule of 78," reference by either phrase shall be sufficient.

(d) Any insurance refund need not be made to the consumer if all refunds and credits due to the consumer amount to less than $1. (Authorized by

K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-108; effective Jan. 1, 1974; amended May 1, 1979; amended May 1, 1986; amended May 1, 1988; amended July 10, 1989.)

40-5-109. Same; experience reports. Each insurer doing consumer credit insurance business in this state shall annually file with the insurance department a report of credit life and credit accident and health business written on a calendar year basis. This report shall utilize the credit insurance supplement-annual statement blank promulgated by the national association of insurance commissioners June 1985. The filing shall be made each year not later than the filing date stated on the most recently adopted "NAIC Credit Insurance Experience Exhibit Form of 1985," which is hereby adopted by reference. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-203; effective Jan. 1, 1974; amended May 1, 1979; amended May 1, 1986; amended May 1, 1988; amended Feb. 9, 1996.)

40-5-110. Same; supervision of credit insurance operations. (a) Each insurer transacting credit insurance in this state shall be responsible to conduct a reasonable annual review of the procedures of each creditor with respect to credit insurance business to insure compliance with the insurance laws of this state and the regulations promulgated by the commissioner.

(b) The review required in subsection (a) shall include a determination that all of the following conditions are met:

(1) The proper charges are being made by the creditor.

(2) The proper refunds are being made.

(3) All claims are being filed and properly handled.

(4) All amounts of insurance payable on death in excess of the amounts necessary to discharge the indebtedness are properly refunded.

(5) The creditor is promptly and fairly processing complaints concerning credit insurance operations and is maintaining proper procedures for, and records of, the complaints processed.

(c) Each insurer shall provide the results of the annual reviews for inspection during an examination, upon the request of the commissioner or the commissioner's designee. (Authorized by K.S.A. 40-103 and K.S.A. 2002 Supp. 16a-4-112; implementing K.S.A. 16a-4-103, 16a-4-104, 16a-4-107, 16a-4-108, and K.S.A. 2002 Supp. 16a-4-112; effective Jan. 1, 1974; amended May 1, 1979; amended May 1, 1986; amended Oct. 17, 2003.)

40-5-111. (Authorized by K.S.A. 40-103, 16a-4-112; implementing K.S.A. 16a-4-101 through 16a-4-203; effective Jan. 1, 1974; amended May 1, 1979; amended May 1, 1986; revoked Aug. 3, 2001.)

Article 6.—INVESTMENTS AND DEPOSITS OF SECURITIES

40-6-1. (Authorized by K.S.A. 40-103, 40-403; effective Jan. 1, 1966; revoked Jan. 1, 1969.)

40-6-2. (Authorized by K.S.A. 40-103, 40-227, 40-403; effective Jan. 1, 1966; amended Jan. 1, 1967; amended Jan. 1, 1968; revoked Jan. 1, 1969.)

40-6-3 and 40-6-4. (Authorized by K.S.A. 40-103, 40-227, 40-404; effective Jan. 1, 1966; revoked Jan. 1, 1969.)

40-6-5. (Authorized by K.S.A. 40-103, 40-227, 40-230, 40-404 *et seq.*; effective Jan. 1, 1967; revoked Jan. 1, 1969.)

40-6-6. (Authorized by K.S.A. 40-103, 40-403 *et seq.*; effective Jan. 1, 1967; revoked Jan. 1, 1969.)

40-6-7. (Authorized by K.S.A. 40-103, 40-229; effective Jan. 1, 1968; revoked Jan. 1, 1969.)

40-6-8. (Authorized by K.S.A. 40-103, 40-2a05, 40-2b05; effective Jan. 1, 1969; amended Jan. 1, 1970; amended Jan. 1, 1973; revoked May 1, 1979.)

40-6-9. (Authorized by K.S.A. 40-103, 40-253, 40-401, 40-402, 40-404, 40-901, 40-1001(a), 40-1027, 40-1102, 40-1104, 40-1204, 40-1519, 40-1605, 40-2a18, 40-2b18; effective Jan. 1, 1969; amended Jan. 1, 1973; revoked May 1, 1979.)

40-6-10. (Authorized by K.S.A. 40-103, 40-2a01 to 40-2a19, inclusive, 40-2b01 to 40-2b20, inclusive; effective Jan. 1, 1969; amended Jan. 1, 1970; amended Jan. 1, 1973; revoked May 1, 1979.)

40-6-11. (Authorized by K.S.A. 40-103, 40-216, 40-2a01 to 40-2a19, inclusive, 40-2b01 to 40-2b20, inclusive; effective Jan. 1, 1969; amended Jan. 1, 1973; revoked May 1, 1979.)

40-6-12. (Authorized by K.S.A. 40-103, 40-

2b09, 40-2b13; effective Jan. 1, 1969; amended Jan. 1, 1973; revoked May 1, 1979.)

40-6-13. (Authorized by K.S.A. 40-103, 40-2a01 to 40-2a19, inclusive, 40-2b01 to 40-2b20, inclusive; effective Jan. 1, 1969; amended Jan. 1, 1970; revoked May 1, 1979.)

40-6-14. (Authorized by K.S.A. 40-103, 40-2a01 to 40-2a19, inclusive, 40-404; effective Jan. 1, 1969; revoked May 1, 1979.)

40-6-15. (Authorized by K.S.A. 40-103, 40-230, 40-404, 40-405, 40-406; effective Jan. 1, 1969; amended Jan. 1, 1973; revoked May 1, 1979.)

40-6-16. (Authorized by K.S.A. 40-103, 40-229; effective Jan. 1, 1969; amended Jan. 1, 1973; revoked May 1, 1979.)

Article 7.—AGENTS

40-7-1. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-239, 40-245, 40-214; effective Jan. 1, 1966; amended Jan. 1, 1974; amended, E-79-25, Oct. 19, 1978; amended May 1, 1979; amended May 1, 1986; revoked Jan. 12, 2007.)

40-7-2. (Authorized by K.S.A. 40-103, 40-214, 40-241; effective Jan. 1, 1966; revoked, E-79-25, Oct. 19, 1978; revoked May 1, 1979.)

40-7-3. (Authorized by K.S.A. 40-103, 40-214, 40-239, 40-240; effective Jan. 1, 1966; revoked, E-79-25, Oct. 19, 1978; revoked May 1, 1979.)

40-7-4. (Authorized by K.S.A. 40-103, 40-239, 40-240; effective Jan. 1, 1966; revoked May 1, 1979.)

40-7-5. Agents; signatures; powers of attorney; rubber-stamped facsimiles; mechanical devices. (a) Each agent licensed by the department shall be prohibited from executing powers of attorney authorizing other individuals to sign policies in the name of the agent.

(b) The placing of the facsimile signature or name and the address of the agent by mechanical means on policies that are issued or sold by or from any vending machine or appliance or any other medium, device, or object designed or used for vending purposes and that provide travel accident coverage only in airports or air terminals shall be acceptable. (Authorized by K.S.A. 40-103 and K.S.A. 2004 Supp. 40-4916; implementing K.S.A. 40-244 and K.S.A. 2004 Supp. 40-4905; effective Jan. 1, 1966; amended May 1, 1981; amended May 1, 1986; amended June 30, 2006.)

40-7-6. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-246; effective Jan. 1, 1966; amended Jan. 1, 1968; amended May 1, 1979; amended May 1, 1981; amended May 1, 1982; amended May 1, 1986; amended May 1, 1987; revoked Aug. 3, 2001.)

40-7-7. Agents; resident procedure for obtaining company certification.(a) The company certification shall be completed to show the company name, the name and address of the agent to be certified, the effective date, and the address of the office submitting the certification.

(b) Company certification shall be made only by an authorized representative of the insurance company or, on and after May 1, 1989, by an authorized representative of a corporation, association, partnership, proprietorship, or other legal entity holding a direct agency appointment from an insurance company.

(c) For purposes of company certification, a licensed director, employee, or nonresident officer of a resident agency shall be deemed to be a resident agent. (Authorized by K.S.A. 40-103 and K.S.A. 2004 Supp. 40-4916; implementing K.S.A. 2004 Supp. 40-4904 and 40-4912; effective Jan. 1, 1966; amended Jan. 1, 1967; amended Jan. 1, 1970; amended, E-70-28, July 1, 1970; amended Jan. 1, 1971; amended, E-71-24, July 1, 1971; amended Jan. 1, 1972; amended Feb. 15, 1977; amended, E-79-25, Oct. 19, 1978; amended May 1, 1979; amended May 1, 1983; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended May 15, 1989; amended Jan. 4, 1993; amended Feb. 8, 1993; amended Dec. 30, 2005.)

40-7-7a. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-246; effective Jan. 4, 1993; revoked Dec. 30, 2005.)

40-7-8. (Authorized by K.S.A. 40-103; effective Jan. 1, 1966; amended Jan. 1, 1972; amended Feb. 15, 1977; revoked, E-79-25, Oct. 19, 1978; revoked May 1, 1979.)

40-7-9. Agents; change in the information contained on the most recent application for a license. Each person licensed in this state as an insurance agent shall report the following to the commissioner of insurance within 30 days of occurrence: (a) Each disciplinary action on the

agent's license or licenses by the insurance regulatory agency of any other state or territory of the United States;

(b) each disciplinary action on an occupational license held by the licensee, other than an insurance agent's license, by the appropriate regulatory authority of this or any other jurisdiction;

(c) each judgment or injunction entered against the licensee on the basis of conduct involving fraud, deceit, or misrepresentation, or a violation of any insurance law;

(d) all details of any conviction of a misdemeanor or felony. The details shall include the name of the arresting agency, the location and date of the arrest, the nature of the charge or charges, the court in which the case was tried, and the disposition rendered by the court. Minor traffic violations may be omitted;

(e) each change in name. If the change of name is effected by court order, a copy of the court order shall be furnished to the commissioner of insurance;

(f) each change in residence address; and

(g) each change in the name or address of the agency with which the agent is associated. (Authorized by K.S.A. 40-103 and K.S.A. 2004 Supp. 40-4916; implementing K.S.A. 2004 Supp. 40-4909; effective Jan. 1, 1966; amended Jan. 1, 1968; amended Jan. 1, 1973; amended, E-76-26, June 16, 1975; amended May 1, 1976; amended May 1, 1986; amended Dec. 30, 2005.)

40-7-10. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-215, 40-241j, 40-241i; effective Jan. 1, 1966; amended Jan. 1, 1967; amended Jan. 1, 1970; amended, E-79-25, Oct. 19, 1978; amended May 1, 1979; amended May 1, 1981; amended May 1, 1986; revoked May 1, 1987.)

40-7-11. Agents; cancellation of licenses or certification; procedure. (a) Licenses or certifications, or both, shall be cancelled upon written request of the agent.

(b) Certifications shall be cancelled upon written request of insurance companies or corporations, associations, partnerships, sole proprietorships and other legal entities acting as insurance agents and holding a direct agency appointment from an insurance company. The cancellation form prescribed by the commissioner shall be submitted to the department upon termination of the contract of the agent. The requesting entity shall notify the agent of certification cancellation. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-241i as amended by L. 1988, Ch. 151; effective Jan. 1, 1966; amended, E-70-28, July 1, 1970; amended Jan. 1, 1971; amended, E-79-25, Oct. 19, 1978; amended May 1, 1979; amended May 1, 1981; amended May 1, 1986; amended April 16, 1990.)

40-7-12. (Authorized by K.S.A. 40-103, K.S.A. 1978 Supp. 40-241; effective Jan. 1, 1966; amended, E-70-28, July 1, 1970; amended Jan. 1, 1971; revoked May 1, 1979.)

40-7-13. Agents; scope, subclassification; type and conduct of examinations; reexamination. (a) The licensing examination for each agent shall test the applicant's knowledge in the following areas:

(1) The laws of Kansas, including:

(A) pertinent provisions of the statutes of Kansas; and

(B) rules and regulations of the insurance department;

(2) general insurance, including:

(A) duties and responsibilities of a licensed agent; and

(B) basic insurance knowledge; and

(3) the specific classes or subclasses of insurance for which application is made.

(b) For examination purposes, the classifications and subclassifications of insurance shall be as follows:

Class	Subclass
(1) Life insurance;	
(2) health insurance;	
(3) casualty insurance;	title insurance and bail bonds;
(4) property insurance;	crop insurance

(c) Persons failing to score at least 70 percent on any examination shall have failed that examination and shall not be qualified for a license for that class or subclass. Notification of the result of each examination shall be provided to the applicant only.

(d) Examinations shall be conducted as follows.

(1) Each applicant shall be advised of eligibility for examination by the commissioner or the commissioner's designee.

(2) The applicant's licensing application shall remain effective for a period of one year from the date received. On and after May 1, 1989, an examination registration shall be effective for a period of 90 days from the date the registration is validated. (Authorized by K.S.A. 40-103, K.S.A. 1991 Supp. 40-241; implementing K.S.A. 1991

Supp. 40-241; effective Jan. 1, 1966; amended Jan. 1, 1968; amended Jan. 1, 1969; amended Jan. 1, 1970; amended, E-70-28, July 1, 1970; amended Jan. 1, 1971; amended, E-71-24, July 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1973; amended Jan. 1, 1974; amended, E-78-24, Sept. 7, 1977; amended May 1, 1978; amended May 1, 1979; amended May 1, 1981; amended May 1, 1982; amended May 1, 1985; amended May 1, 1986; amended May 1, 1987; amended Dec. 26, 1988; amended May 15, 1989; amended Feb. 8, 1993.)

40-7-14. (Authorized by K.S.A. 40-103, 40-241c; effective Jan. 1, 1966; revoked May 1, 1979.)

40-7-15. (Authorized by K.S.A. 40-103, 40-240, 40-241; effective Jan. 1, 1966; revoked May 1, 1979.)

40-7-16. (Authorized by K.S.A. 40-103, 40-246, 40-401; effective Jan. 1, 1966; amended Jan. 1, 1968; revoked May 1, 1979.)

40-7-17. (Authorized by K.S.A. 40-103, 40-240, 40-241, 40-252; effective Jan. 1, 1972; revoked May 1, 1979.)

40-7-18. (Authorized by K.S.A. 40-103, 40-240, 40-246; effective Jan. 1, 1973; revoked May 1, 1979.)

40-7-19. Agents; individual records; fees. (a) Each person, company, or organization requesting a paper copy of any verification of license record, duplicate license, certification of home state, or clearance letter from the commissioner shall pay a fee of $10.00.

(b) The fee established by this regulation shall be charged for each document requested and shall not be refunded for any reason. (Authorized by K.S.A 40-103, 40-241k; implementing K.S.A. 40-241k; effective May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended Jan. 4, 1993; amended June 8, 2007.)

40-7-20. (Authorized by and implementing L. 1986, ch. 170, Sec. 1; effective, T-88-1, Jan. 5, 1987; effective May 1, 1987; revoked May 15, 1989.)

40-7-20a. Agents; continuing education; approval of courses; requirements. (a) Definitions. For the purposes of this regulation, the following definitions shall apply:

(1) "Coordinator" means an individual who is responsible for monitoring continuing education offerings.

(2) "Course" means a series of lectures or lessons that deals with a particular subject following a prearranged agenda or study plan and that may culminate in a written examination.

(3) "Instructor" means an individual lecturing in a continuing education offering.

(4) "Licensee," "licensed agent" and "agent" mean a natural person licensed by this state as an agent.

(5) "Person" means a natural person, firm, institution, partnership, corporation, or association.

(6) "Provider" and "providing organization" mean a person or firm offering or providing insurance education.

(7) "Self-study courses" means courses that are primarily delivered or conducted in other than a classroom setting or with on-site instruction and are designed to be completed independently by the student.

(b) General requirements.

(1) Only courses that impart substantive and procedural knowledge relating to insurance and are beneficial to the insuring public after initial licensing shall be approved for credit. Approved courses shall be classified as life, health, and variable contracts courses; property and casualty courses; general courses; ethics courses; or general management courses. Credit earned from general courses, ethics courses, or general management courses shall be acceptable in meeting the requirements for the property and casualty insurance or the life and health insurance license classifications.

(2) Courses of the following types shall not meet the basic criteria for approvable courses described in paragraph (1) of this subsection:

(A) Courses designed to prepare students for a license examination;

(B) courses in office or business skills, including typing, speed reading, and the use of calculators or other machines or equipment; and

(C) courses in sales promotion, including meetings held in conjunction with the general business of the licensee.

(3)(A) Each licensee shall attend a course in its entirety in order to receive full credit.

(B) Upon completion of each approved course, the student shall receive credit for the number of hours approved for the course, which shall be equivalent to one hour of credit for each hour of instruction.

(C) If the number of credit hours for which a course is approved is fewer than the total number of hours of the course presentation, the student shall attend the entire course in order to receive credit for the number of approved hours.

(D) The number of approved hours shall not include time spent on introductions, breaks, or other activities not directly related to approved educational information or material.

(E) Neither a student nor an instructor shall earn full credit for attending or instructing any subsequent offering of the same course in the current biennial license period after attending or teaching the course.

(4) Course examinations shall not be required for approval of continuing education courses except self-study courses.

(5) Each provider shall submit proposed courses to the commissioner or the commissioner's designee for preapproval at least 30 days before the date on which the course is to be held.

(6) An advertisement shall not state or imply that a course has been approved by the commissioner or the commissioner's designee unless written confirmation of this approval has been received by the provider.

(7) If approval has been granted for the initial offering of a course, approval for subsequent offerings not disclosed in the initial submission may be obtained by providing written notification to the commissioner or the commissioner's designee at least 30 days before the date the program is to be held, indicating that no change has been made in the course and specifying the additional times and places the course will be presented.

(8) The provider shall submit all fees required for individual course approval with the course submission. If the provider elects to pay the prescribed fee for all courses, the provider shall pay the fee annually and shall submit the fee with the first course submission each year.

(9) Each course of study, except self-study courses, shall be conducted in a classroom or other facility that comfortably accommodates the faculty and the number of students enrolled. The provider may limit the number of students enrolled in a course.

(10)(A) Each successfully completed course leading to a nationally or regionally recognized designation shall receive credit as approved by the commissioner or the commissioner's designee.

(B) Any agent attending at least 80 but less than 100 percent of regularly scheduled classroom sessions for any single course may receive full educational credit if the course is filed as a formal classroom course. This credit may be earned to the extent that adequate records are maintained and appropriate certification of such attendance is provided by the course instructor.

(11)(A) The amount of credit received by an agent for a self-study course shall be based upon successful completion of the course and an independently monitored examination subject to the number of hours assigned by the commissioner or the commissioner's designee.

(B) Examination monitors shall not be affiliated in any way with the providing organization or the licensee and shall be subject to approval by the commissioner or the commissioner's designee. Each examination utilized or to be utilized shall be included in the material submitted for course approval. No examination shall be approved unless the commissioner is satisfied that security procedures protecting the integrity of the examination can be maintained. If security is compromised, no credit shall be granted.

(C) Each provider of self-study courses shall clearly disclose to any agent wishing to receive credit in Kansas the number of hours for which that particular course has been approved by the commissioner or the commissioner's designee.

(c) Each licensee or provider found to have falsified a continuing education report to the commissioner shall be subject to suspension or revocation of the licensee's or provider's insurance license in accordance with K.S.A. 40-4909 and amendments thereto, a penalty as prescribed in K.S.A. 40-254 and amendments thereto, or termination of approval as a provider.

(d) Course requirements.

(1) Each course of study shall have a coordinator who is responsible for supervising the course and ensuring compliance with the statutes and regulations governing the offering of insurance continuing education courses.

(2)(A) Each provider and each providing organization shall maintain accurate records relating to course offerings, instructors, and student attendance. If the coordinator leaves the employ of the provider or otherwise ceases to monitor continuing education offerings, the records shall be transferred to the replacement coordinator or an officer of the provider. If a provider ceases operations, the coordinator shall maintain the records or provide a custodian of the records acceptable to the commissioner. In order to be acceptable, a

custodian shall agree to make copies of student records available to students free of charge or at a reasonable fee. The custodian of the records shall not be the commissioner, under any circumstances.

(B) Each provider shall provide students with course completion certificates, on a form prescribed or approved by the commissioner, within 30 days after completion of the course. A provider may require payment of the course tuition as a condition for receiving the course completion certificate.

(3) Each instructor shall possess at least one of the following qualifications:

(A) Recent experience in the subject area being taught;

(B) a college degree related to the subject area being taught; or

(C) an appropriate professional designation in the area being taught.

(4) Each instructor shall perform the following:

(A) Comply with all laws and regulations pertaining to insurance continuing education;

(B) provide the students with current and accurate information;

(C) maintain an atmosphere conducive to learning in a classroom; and

(D) provide assistance to the students and respond to questions relating to course material.

(5) Each provider, coordinator, and instructor shall notify the commissioner within 10 days after the occurrence of any of the following:

(A) A felony or misdemeanor conviction or disciplinary action taken against a provider or against an insurance or other occupational license held by the coordinator or instructor; and

(B) any change of information contained in an application for course approval.

(e) Licensee reporting requirement.

(1) Each licensee shall report continuing education credit on forms and in a manner prescribed by the commissioner. Each course shall be completed or attended during the reporting period for which the credit hours are to be applied.

(2) Each request for an extension permitted by K.S.A. 40-4903(j) and amendments thereto shall be submitted in writing not later than the reporting deadline and shall include an explanation and independent verification of the hardship. (Authorized by K.S.A. 40-103 and K.S.A. 2005 Supp. 40-4916; implementing K.S.A. 2005 Supp. 40-4903; effective May 15, 1989; amended, T-40-8-28-90, Aug. 30, 1990; amended Oct. 15, 1990; amended Feb. 8, 1993; amended April 11, 1997; amended Feb. 9, 2007.)

40-7-21. Agents; examination fee; amount. On and after May 1, 1989, each person attempting to pass the examination shall pay the following fees for each attempt to pass the examination:

(a) $62 for each single line examination of 100 items or limited line examination of up to 50 items; or

(b) $85 for each combination examination of 130 items or more covering two or more lines of coverage included in two different classes of insurance as prescribed K.A.R. 40-7-13. (Authorized by and implementing K.S.A. 40-241, as amended by L. 1996, Ch. 45, Sec. 2; effective, T-88-1, Jan. 5, 1987; effective May 1, 1987; amended, T-40-3-31-89, May 1, 1989; amended May 15, 1989; amended April 11, 1997.)

40-7-22. Agents; appointment by company; classes of business. Each insurance company shall appoint each agent in any agency that represents the company, for each class of business that the agent is qualified to transact. (Authorized by K.S.A. 40-103, K.S.A. 2004 Supp. 40-4916; implementing K.S.A. 2004 Supp. 40-4912; effective April 16, 1990; amended Sept. 16, 2005.)

40-7-23. Agents; license; identification. Each business entity holding a contract with an insurance company under the business entity's "doing business as" (DBA) name shall be licensed in the "DBA" name. (Authorized by K.S.A. 40-103, K.S.A. 2004 Supp. 40-4916; implementing K.S.A. 40-4905(d); effective April 16, 1990; amended Sept. 16, 2005.)

40-7-24. Agencies; agents; employees. Each business entity holding an agency license shall have at least one licensed agent in its employ, except any business entity offering only credit life or credit health insurance products or auto rental products. (Authorized by K.S.A. 40-103, K.S.A. 2005 Supp. 40-4916; implementing K.S.A. 2005 Supp. 40-4904(b)(8) and (10); effective April 16, 1990; amended Jan. 12, 2007.)

40-7-25. Agencies; termination of contract; certification. The termination of an agency's contract by an insurer shall automatically terminate the certification of each individual

agent in that agency if the certification of each agent is derived solely from the agency's certification. (Authorized by K.S.A. 40-103 and K.S.A. 2005 Supp. 40-4916; implementing K.S.A. 2005 Supp. 40-4912; effective April 16, 1990; amended April 27, 2007.)

Article 8.—EXCESS COVERAGE

40-8-1. (Authorized by K.S.A. 40-103, 40-246b, 40-246c, 40-246d; effective Jan. 1, 1966; revoked May 1, 1979.)

40-8-2. Excess line insurance; refusal of admitted carriers; rate differentials; artificial divisions of coverage; portions of risk unacceptable. Risks which may be written but are declined by admitted insurers may be placed with non-admitted insurers in accordance with K.S.A. 40-246b subject to the following conditions:

(a) When the coverage sought would be acceptable as a single contract to admitted insurers, artificial divisions of coverage into two or more proposed contracts shall be prohibited for the purpose of:

(1) Rendering a portion of the coverage unacceptable to admitted companies; or

(2) obtaining a rate advantage upon the entire risk.

(b) With prior approval of the commissioner, a risk involving a single class of coverage may be placed with a non-admitted insurer if a portion of the risk is unacceptable to admitted insurers and the non-admitted insurer will not write the unacceptable portion separately.

(c) A risk shall not be placed with a non-admitted insurer if the risk includes a combination of classes of insurance that may be procured from separate admitted insurers under separate contracts.

(d) A risk shall not be placed with a non-admitted insurer if the risk includes a combination of classes of insurance that a single admitted insurer is prohibited from writing in either a single contract or in separate contracts, or both. In these cases, separate forms of contracts, each incorporating a class or a lawful combination of classes, shall be offered to and refused by admitted insurers for each class or combination of classes, before the insurance can be placed with non-admitted insurers. (Authorized by K.S.A. 40-103; implementing K.S.A. 1984 Supp. 40-246b; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1983; amended May 1, 1986.)

40-8-3. (Authorized by K.S.A. 40-103, 40-246c, 40-246d, K.S.A. 1978 Supp. 40-246b; effective Jan. 1, 1966; amended Jan. 1, 1968; revoked May 1, 1979.)

40-8-4 and 40-8-5. (Authorized by K.S.A. 40-103, 40-246c, 40-246d, K.S.A. 1978 Supp. 40-246b; effective Jan. 1, 1966; revoked May 1, 1979.)

40-8-6. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-246d, 40-246b, 40-246e; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986; revoked May 1, 1987.)

40-8-7. Excess lines insurance; agents; submission of affidavit required. (a) The excess lines agent who actually places business with a non-admitted insurer shall file the affidavit and annual statement reporting forms prescribed by the commissioner. Other excess lines agents shall file only the affidavit form prescribed by the commissioner. Each excess line agent shall file the appropriate form or forms with the department, on or before March 1st of each year, and shall include a tax remittance in the amount of 6% of the gross premium for all policies written on risks that were placed during the preceding calendar year.

(1) "Gross premium" means the amount charged to the insured for the insurance procured. When an audit or gross receipts contract requires a deposit premium, the amount collected during the calendar year either as a deposit or partial payment shall be reported on the affidavit and annual statement reporting forms as gross premium for that calendar year. Gross premium shall not include the tax due on the premium nor shall that tax be charged to the insured unless specifically identified and provided for in the policy.

(2) When a policy is renewed or an adjustment, addition, or reduction is made on a risk previously placed, the excess lines agent shall make the appropriate adjusting entry on the annual statement reporting form.

(b) If the excess lines agent fails to submit a statement and pay the premium tax as required by subsection (a) of this regulation, an assessment equalling two times the amount of excess premium tax required by K.S.A. 40-246c shall be collected by the commissioner. This subsection shall not apply under the following circumstances:

(1) If the required statement and excess premium tax payment is submitted by mail on or before the 1st day of March of each year;

(2) if the required statement and the excess premium tax payment is received by the commissioner before the 1st day of January of each year and the statement and premium include all transactions of the excess coverage licensee during the year; or

(3) if the required statement and excess premium tax payment is not received by the commissioner because no transactions contemplated by the statute occurred during the preceding year. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-246b, as amended by L. 1996, Ch. 45, Sec. 3, 40-246c; effective Jan. 1, 1966; amended Jan. 1, 1968; amended Jan. 1, 1970; amended Jan. 1, 1971; amended, E-76-29, June 19, 1975; amended May 1, 1976; amended May 1, 1979; amended, T-83-22, Aug. 11, 1982; amended May 1, 1983; amended May 1, 1984; amended May 1, 1986; amended May 1, 1987; amended, T-40-10-23-92, Oct. 23, 1992; amended Feb. 8, 1993; amended May 16, 1997.)

40-8-8. Excess line insurance contracts; signature of agents; required endorsement. Each insurance contract procured and delivered as excess coverage pursuant to K.S.A. 40-246b shall bear the signature of the agent who placed the coverage with a non-admitted insurer. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-246d, K.S.A. 1984 Supp. 40-246b, 40-246c; effective Jan. 1, 1966; amended Jan. 1, 1970; amended May 1, 1979; amended, T-83-22, Aug. 11, 1982; amended May 1, 1983; amended May 1, 1986.)

40-8-9. (Authorized by K.S.A. 40-103; effective Jan. 1, 1966; amended Jan. 1, 1967; amended, E-76-29, June 19, 1975; amended May 1, 1976; revoked May 1, 1979.)

40-8-10. Agents; placing risks with employer prohibited. Any excess line agent shall not place risks or effect insurance or reinsurance for themselves, or for the persons, company, or corporation with whom the excess line agent is employed. (Authorized by K.S.A. 40-103; implementing K.S.A. 1984 Supp. 40-246b; effective Jan. 1, 1966; amended, E-76-29, June 19, 1975; amended May 1, 1976; amended May 1, 1979; amended May 1, 1986.)

40-8-11. Excess line agents; records required. The record required to be maintained by each excess lines agent pursuant to K.S.A 1985 Supp. 40-246b shall include the following:

(a) A duplicate copy of the combined affidavit-annual statement;

(b) the exact amount of each kind of insurance permitted under this act which has been procured for each assured;

(c) the home address of the insurer and the kind or kinds of insurance effected;

(d) the address of the insured, and a brief description of the property insured;

(e) the insurance cancelled or added, and its premiums; and

(f) a duplicate of the policy with each rider, endorsement, and attachment.

(g) Evidence that the information and consent of the insured required by K.S.A. 1985 Supp. 40-246b was provided and obtained. (Authorized by K.S.A. 40-103; implementing K.S.A. 1985 Supp. 40-246b, 40-246c; effective Jan. 1, 1966; amended Jan. 1, 1968; amended Jan. 1, 1970; amended, T-83-22, Aug. 11, 1982; amended May 1, 1983; amended May 1, 1986; amended May 1, 1987.)

40-8-12. (Authorized by K.S.A. 40-103; effective Jan. 1, 1966; amended Jan. 1, 1973; amended, E-76-29, June 19, 1975; amended May 1, 1976; revoked May 1, 1979.)

40-8-13. (Authorized by K.S.A. 40-103, 40-2001 *et seq.*; effective Jan. 1, 1966; revoked May 1, 1979.)

Article 9.—ADVERTISING

40-9-1. Insurance companies; advertising; assets and liabilities; capital; advertisement defined. (a) Whenever any insurance company doing business in this state advertises its assets, the insurance company shall advertise its liabilities in the same connection and in a manner equally conspicuous. The amount of company liability in an advertisement shall be the amount determined in the manner required in making the annual statements to this department, and the amount of its assets shall be the admitted assets of the company. In the case of a company organized under the laws of a foreign country, its assets shall be considered only the amount deposited with the official of the several states of the union or held by trustees in the United States for the benefit of the policyholders and creditors of the company in the United States.

(b) Each advertisement purporting to show the capital of any insurance company doing business

in this state shall exhibit only the amount of capital actually paid up in cash.

(c) Each policy, sign, circular, card, or other means by which public announcements are made, shall be held to be an advertisement within the meaning of K.A.R. 40-9-1. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-235; effective Jan. 1, 1966; amended May 1, 1986.)

40-9-2 to 40-9-22. (Authorized by K.S.A. 40-103, 40-2401 *et seq.*; effective Jan. 1, 1966; revoked Jan. 1, 1974.)

40-9-23 to 40-9-99. Reserved.

40-9-100. Accident and sickness insurance; advertising. The national association of insurance commissioners' "advertisements of accident and sickness insurance model regulation," April 1999 edition, is hereby adopted by reference, subject to the following exceptions:

(a) Section 1 is not adopted.

(b) Section 13 C is not adopted by reference and is replaced with the following language: "An advertisement which is seen or heard in this state shall not directly or indirectly create the impression that the policy being advertised is approved for issuance in the state, unless that is the fact. If the policy is not approved for issuance in this state, that fact shall be disclosed in the advertisement by a statement reading, 'This policy is not available in Kansas.' "

(c) Section 16 A(2) is completed by the insertion of "6" in the space requiring specification of a number of months.

(d) Section 18 B is not adopted. (Authorized by K.S.A. 40-2404a; implementing K.S.A. 1999 Supp. 40-2404(1); effective May 1, 1982; amended May 1, 1987; amended June 22, 2001.)

40-9-101. (Authorized by K.S.A. 40-2404a; implementing K.S.A. 40-2404 (1) and (2); effective, E-73-13, May 1, 1973; effective Jan. 1, 1974; amended May 1, 1975; amended May 1, 1979; revoked May 1, 1982.)

40-9-102. (Authorized by K.S.A. 40-2404a; implementing K.S.A. 40-2404 (1) and (2); effective, E-73-13, May 1, 1973; effective Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1982.)

40-9-103 and 40-9-104. (Authorized by K.S.A. 40-2404a; implementing K.S.A. 40-2404 (1) and (2); effective, E-73-13, May 1, 1973; effective Jan. 1, 1974; revoked May 1, 1982.)

40-9-105 to 40-9-107. (Authorized by K.S.A. 40-2404a; implementing K.S.A. 40-2404 (1) and (2); effective, E-73-13, May 1, 1973; effective Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1982.)

40-9-108. (Authorized by K.S.A. 40-2404a; implementing K.S.A. 40-2404 (1) and (2); effective, E-73-13, May 1, 1973; effective Jan. 1, 1974; revoked May 1, 1982.)

40-9-109. (Authorized by K.S.A. 40-2404a; implementing K.S.A. 40-2404 (1) and (2); effective, E-73-13, May 1, 1973; effective Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1982.)

40-9-110 and 40-9-111. (Authorized by K.S.A. 40-2404a; implementing K.S.A. 40-2404 (1) and (2); effective, E-73-13, May 1, 1973; effective Jan. 1, 1974; revoked May 1, 1982.)

40-9-112. (Authorized by K.S.A. 40-2404a; implementing K.S.A. 40-2404 (1) and (2); effective, E-73-13, May 1, 1973; effective Jan. 1, 1974; amended May 1, 1975; revoked May 1, 1982.)

40-9-113 to 40-9-116. (Authorized by K.S.A. 40-2404a; implementing K.S.A. 40-2404 (1) and (2); effective, E-73-13, May 1, 1973; effective Jan. 1, 1974; revoked May 1, 1982.)

40-9-117. (Authorized by K.S.A. 40-2404a; effective Feb. 15, 1977; revoked May 1, 1979.)

40-9-118. Life insurance; advertising. The national association of insurance commissioners' rules governing the advertising of life insurance, June 1988 edition, are hereby adopted by reference subject to the following exceptions. (a) Sections I, XI, XII, subsection 24 of section V, and subsection 3 of section IX are not adopted.

(b) Section V, 20(d) is completed by insertion of "6" in the space requiring specification of a number of months. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 1997 Supp. 40-2404(l); effective Feb. 15, 1977; amended May 1, 1979; amended May 1, 1986; amended May 1, 1987; amended May 1, 1988; amended Jan. 4, 1993; amended July 10, 1998.)

40-9-119 to 40-9-125. (Authorized by K.S.A. 40-103, 40-2404a; implementing K.S.A. 40-2404(1); effective Feb. 15, 1977; amended May 1, 1986; revoked May 1, 1987.)

Article 10.—FIREFIGHTER'S RELIEF FUND TAX

40-10-1. Firefighter's relief fund tax; fire marshal tax; companies subject to; amount of premiums taxed. (a) Each insurance company, authorized to transact business in the state of Kansas, that issues a policy which covers the hazard of fire is subject to the firefighter's relief fund tax and the fire marshal tax. Unless a verifiable, separate charge is made for fire coverage, the following portion of the respective policy premiums shall be allocated as fire premium:

(1) 25 percent of all premium collected on homeowners multiple-peril policies;

(2) 55 percent of all premium collected on the property coverage section of commercial multiple-peril policies;

(3) 20 percent of all premium collected on aircraft policies;

(4) eight percent of all premium collected on automobile physical damage coverage;

(5) 15 percent of all premium collected on marine policies;

(6) 35 percent of all premium collected on farmowners multiple-peril policies; and

(7) 33⅓ percent of all premium on all other single premium policies that provide coverage for damage caused by fire and perils other than fire.

(b) The words "fire insurance company" as used in K.S.A. 75-1508, and any amendments, are construed to mean each company issuing a policy which includes coverage for property against the hazard of fire. (Authorized by K.S.A. 40-103, 40-1707(g); implementing K.S.A. 1984 Supp. 75-1508, K.S.A. 1984 Supp. 40-1703; effective Jan. 1, 1966; amended May 1, 1981; amended May 1, 1985; amended May 1, 1986.)

40-10-2. Firefighter's relief association; requirements for participation; procedure. (a) Members of a fire department who desire to participate in the distribution of firefighter's relief funds shall meet these requirements:

(1) Apply for a charter and incorporate as a not-for-profit corporation;

(2) file with the commissioner of insurance a certified copy of the articles of incorporation of the firefighter's relief association; and

(3) file with the commissioner of insurance evidence of establishment of a fire district within a township or county in accordance with applicable Kansas statutes. This requirement shall not apply to fire departments under the exclusive control of the governing body of an incorporated city.

(b) When the members of a city, township, county, or fire district fire department notify the commissioner of insurance of their desire to participate in the firefighter's relief fund tax and have otherwise qualified for participation, the proper officials shall complete a declaration form, provided by the commissioner, that declares their right to participate in the firefighter's relief fund. The completed form shall be returned to the commissioner. The declaration form shall be executed by the chief executive officer of the city, township, county, or fire district. The clerk of the city, township, or county, or the equivalent official of the fire district shall attest to the execution of the form.

(c) A declaration form shall be filed annually with the commissioner of insurance.

(d) Qualified firefighter's relief associations shall submit for newly established associations and for associations requesting redetermination hearings pursuant to K.S.A. 40-1706(c)(6), on forms provided by the commissioner, a certification by the county clerk, of the population and assessed tangible property valuation of the geographic area provided fire protection services by the fire department of the association. The population figure shall be computed using the most recent population figures available from the United States bureau of the census, as certified to the secretary of state by the division of the budget on July 1 of each year. The assessed tangible property valuation figure provided on the form shall be computed using the tangible assessed valuation, as shown on the latest November 1 assessment roll prepared and maintained by the county clerk.

(e) Each firefighter's relief association shall adopt bylaws to cover all activities of the association and shall set forth the procedures for disbursing funds for the payment of benefits provided by the association. A copy of the bylaws and the procedures shall be filed with the commissioner. (Authorized by K.S.A. 40-103, 40-1707(g); implementing K.S.A. 40-1701; effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1981; amended May 1, 1985; amended May 1, 1986; amended Oct. 17, 1997.)

40-10-3. (Authorized by K.S.A. 40-103, 17-3001(C); effective Jan. 1, 1966; revoked May 1, 1979.)

40-10-4. (Authorized by K.S.A. 40-103, 40-

1701 *et seq.*; effective Jan. 1, 1966; revoked May 1, 1979.)

40-10-5. Firefighter's relief associations; purchase of insurance; on duty coverage. (a) Except as provided in K.S.A. 40-1707(b), 40-1707(c)(1)(A) and 40-1707(c)(1)(B), and its amendments, any insurance for coverage while on duty which is paid for in whole or in part by a firefighter's relief association from funds paid by the commissioner of insurance shall meet the following conditions:

(1) Each policy shall be purchased, owned and held by the firefighter's relief association.

(2) Each policy shall name the firefighter's relief association as beneficiary of the policy. The policy shall not contain a provision which would permit the beneficiary to be other than a firefighter's relief association.

(3) The policy shall provide that each indemnity shall be paid to the firefighter's relief association.

(4) Except as provided by subsection (b), the policy shall be limited to cover only accidental injuries, diseases, or death resulting from duties as a member of the fire department as set forth in K.S.A. 40-1707.

(b) Each volunteer fire department may establish annuities in accordance with K.S.A. 40-1707(c)(1), and its amendments. Prior to the purchase of any annuity contract by a firefighter's relief association for and on behalf of the volunteer firefighters, the purchase of the annuity contract shall be approved by the attorney of the governing body.

(c) K.S.A. 40-1707(c)(1)(A) and 40-1707(c)(1)(B), and its amendments, shall be applicable only to group term, group permanent or individual permanent life insurance contracts. (Authorized by K.S.A. 40-103, 40-1707(g); implementing K.S.A. 1984 Supp. 40-1707; effective Jan. 1, 1966; amended Jan. 1, 1968; amended May 1, 1975; amended May 1, 1979; amended May 1, 1985; amended May 1, 1986.)

40-10-6. Firefighter's relief associations; purchase of insurance; 24 hour coverage. (a) Except as provided in K.S.A. 40-1707(b), 40-1707(c)(1)(A) and 40-1707(c)(1)(B), and its amendments, any insurance for 24 hour coverage which is paid in part by a firefighter's relief association from funds paid to it by the commissioner of insurance shall meet the following conditions:

(1) Each policy shall be purchased, owned, and held by the firefighter's relief association.

(2) Except as provided in subsection (b)(4), each policy shall name the firefighter's relief association as the beneficiary of the policy. The policy shall not contain a provision which would permit the beneficiary to be other than a firefighter's relief association.

(3) Except as provided in subsection (b)(4), the insurance policy shall provide that each indemnity shall be paid to the firefighter's relief association.

(b) Where individual members of a firefighter's relief association desire to have their dependents insured under a group or franchise accident and health policy issued to the association:

(1) Dependent's coverage shall be evidenced by endorsements attached to the policy.

(2) The association shall have authorized the addition of coverage for dependents to its policy.

(3) The cost of coverage for dependents shall be paid by the individual firefighter. Firefighter's relief tax funds cannot be used to pay for the coverage.

(4) The endorsement shall provide that benefits under the endorsement for dependents shall be paid directly to the firefighter who has paid for them or to another beneficiary of the firefighter's choice. The association shall not be a beneficiary.

(c) When a firefighter's relief association purchases 24 hour coverage for its members, each individual member shall pay that portion of the cost (premiums) which is beyond "on duty" coverage. The contribution by the individual members shall not be less than 15 percent of the total premium for this coverage.

(d) K.S.A. 40-1707(c)(1)(A) and 40-1707(c)(1)(B), and its amendments, shall be applicable only to group term, group permanent or individual permanent life insurance contracts. (Authorized by K.S.A. 40-103, 40-1707(g); implementing K.S.A. 1984 Supp. 40-1707; effective Jan. 1, 1966; amended Jan. 1, 1968; amended May 1, 1975; amended May 1, 1979; amended May 1, 1985; amended May 1, 1986.)

40-10-7 to 40-10-9. (Authorized by K.S.A. 40-103, 40-1701 *et seq.*; effective Jan. 1, 1966; revoked May 1, 1979.)

40-10-10. Firefighter's relief association; permissible disbursements. The cost of the bond for the treasurer of a firefighter's relief association, as prescribed by K.S.A. 40-1706, and reasonable administrative expenses, to be deter-

mined at the discretion of the commissioner of insurance, including stamps, stationery, safe deposit box rent, the expense of having the funds of the association audited, and other similar expenses, shall be permissible disbursements from the firefighter's relief funds. Each expenditure shall be itemized in the financial statement. (Authorized by K.S.A. 40-103, 40-1707(g); implementing K.S.A. 40-1707(g); effective Jan. 1, 1966; amended May 1, 1979; amended May 1, 1986; amended Oct. 17, 1997.)

40-10-11 to 40-10-13. (Authorized by K.S.A. 40-103, 40-1701 *et seq.*; effective Jan. 1, 1966; revoked May 1, 1979.)

40-10-14. Same; purchase of bonds; requirements. Each bond purchased with firefighter's relief funds shall be shown on the financial statement at the initial purchase price. Bonds shall not be carried at market or maturity value. When the bonds mature or are sold, each change in the value from the initial purchase price shall be reflected in the financial statement. (Authorized by K.S.A. 40-103, 40-1707(g); implementing K.S.A. 40-1706; effective Jan. 1, 1966; amended May 1, 1986; amended May 1, 1987.)

40-10-15. Firefighters relief act; application of statutory formula. In applying the formula set forth in L. 1987, Ch. 168, Sec. 1(c)(5), the result of the calculation prescribed by subsection (A)(ii) and (B)(ii) shall be the "amount received from taxes collected for all of calendar year 1983" referenced in subsections (A)(iv) and (B)(iv) respectively. (Authorized by L. 1987, Ch. 168, Sec. 2(g); implementing L. 1987, Ch. 168, Sec. 1(c)(5); effective, T-88-21, July 1, 1987; amended May 1, 1988.)

Article 11.—PROXIES, CONSENTS AND AUTHORIZATIONS

40-11-1 to 40-11-7. (Authorized by K.S.A. 40-264 *et seq.*, 40-272; effective Jan. 1, 1966; amended Jan. 1, 1970; revoked May 1, 1980.)

40-11-8. Reserved.

40-11-9 to 40-11-11. (Authorized by K.S.A. 40-264 *et seq.* , 40-272; effective Jan. 1, 1966; amended Jan. 1, 1970; revoked May 1, 1980.)

40-11-12. Domestic stock insurance companies; proxies, consents and authorizations; application of regulation. The national association of insurance commissioners regulation regarding proxies, consents and authorizations of domestic stock insurers, June 1980 edition, is hereby adopted by reference. (Authorized by K.S.A. 40-103, 40-272; implementing K.S.A. 40-272; effective May 1, 1980; amended May 1, 1981; amended May 1, 1986.)

Article 12.—SALE OF STOCK

40-12-1. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-209a; effective Jan. 1, 1966; amended May 1, 1980; amended May 1, 1986; revoked May 25, 2001.)

40-12-2 and 40-12-3. (Authorized by K.S.A. 40-103, K.S.A. 1965 Supp. 40-204, 40-205; effective Jan. 1, 1966; revoked Jan. 1, 1968.)

40-12-4. Stock insurance companies; sale of stock; permit; amount paid-in; requirements. A domestic insurance company in the process of organization and offering its stock for sale under a permit issued by the commissioner of insurance shall not be issued a certificate of authority to transact the business of insurance, as required by K.S.A. 40-214, until the full amount of stock authorized under the permit has been paid-in. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effective Jan. 1, 1966; amended May 1, 1986.)

40-12-5. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effective Jan. 1, 1966; amended May 1, 1980; amended May 1, 1986; revoked May 1, 1987.)

40-12-6. Stock insurance companies; sale of stock; permits; holding companies. A permit shall not be issued to a domestic insurance company in the process of organization where the company's stock plan provides that sufficient shares to effect control of the insurance company shall be issued to a holding company or other legal entity which is offering for sale shares of its authorized but unissued stock or of its treasury stock. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-204, 40-205; effective Jan. 1, 1966; amended May 1, 1980; amended May 1, 1986.)

40-12-7. Stock insurance companies; sale of stock; permits; organizers and promoters; requirements. Except as provided in

K.A.R. 40-12-8, the organizers and promoters of a domestic insurance company in the process of organization shall, as a group and prior to the offer or sale of any shares of stock to any other person, purchase for their own account shares equal to not less than 20 percent of the total number of shares to be offered under the permit. Each share of stock of a domestic insurance company in the process of organization purchased directly or indirectly by its organizers and promoters shall be deposited in escrow pursuant to an escrow agreement approved by the commissioner of insurance. The escrow agreement shall include a provision that the shares shall not be sold, transferred, assigned, encumbered, or alienated in any manner except by operation of law without the prior approval of the commissioner of insurance for such period of time as the commissioner shall deem reasonable, necessary, or advisable to protect the interests of the company, its policyholders and stockholders. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effective Jan. 1, 1966; amended May 1, 1980; amended May 1, 1986.)

40-12-8. Stock insurance companies; sale of stock; permits; organizers and promoters; holding companies; requirements. (a) When the plan by which a domestic insurance company in the process of organization proposes to offer its stock for sale provides that the insurance company shall be sponsored by a holding company or other legal entity which will subscribe for and purchase sufficient shares to control the operation of the insurance company, the organizers and promoters of the insurance company shall not be subject to K.A.R. 40-12-7.

(b) When the provision of paragraph (a) shall apply, each share of the insurance company purchased by the organizers and promoters and each share purchased by the holding company or other legal entity shall be deposited in escrow pursuant to an escrow agreement approved by the commissioner of insurance.

(c) The escrow agreement shall include a provision that the shares shall not be sold, transferred, assigned, encumbered or alienated in any manner except by operation of law without the prior approval of the commissioner of insurance. The sale restriction shall be effective for a period of time as the commissioner shall deem reasonable, necessary or advisable to protect the interests of the company, its policyholders, and stockholders. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effective Jan. 1, 1966; amended May 1, 1980; amended May 1, 1986.)

40-12-9. Impounding of stock sale proceeds; when required; impound agent; certificates of no lien. (a) A permit issued to a domestic stock insurer prior to a certificate of authority shall require 100 percent of all stock sale proceeds to be impounded until release upon written order of the commissioner. This requirement shall not apply if the applicant can demonstrate to the commissioner's satisfaction that an impoundment of funds is not necessary to guarantee full return of stock purchase moneys in the event a certificate of authority is not issued. If the applicant does not qualify for a certificate of authority within two years, subscription money shall be returned in full to all subscribers without deduction of expenses. Extensions beyond two years shall not be granted without the consent of all subscribers.

(b) Application for a permit which will entail impoundment of stock sale proceeds shall name a duly authorized bank or trust company within the state which has consented to act as impound agent.

(c) Before an order is made releasing stock sale proceeds from impoundment, written assurance shall be requested from the bank or trust company serving as impound agent that it has no lien, general, special, bankers, or otherwise, against the funds, and knows of no claims asserted against the funds. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effectiveJan. 1, 1968; amended May 1, 1980; amended May 1, 1986; amended May 1, 1987.)

40-12-10. Promotional stock. Stock issued for consideration of the promotion of a domestic stock insurer shall be prohibited. The prohibition does not preclude, for promoters, officers or employees, a stock option plan which meets the standards set forth in Kansas administrative regulation 40-12-12(a). (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effective Jan. 1, 1968; amended May 1, 1980; amended May 1, 1981; amended May 1, 1986; amended May 1, 1987.)

40-12-11. Sales to promoters. In the event of a public offering, a security of a domestic insurer shall not be authorized for promoters at less than the net offering price. (Authorized by

K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effective Jan. 1, 1968; amended May 1, 1980; amended May 1, 1986; amended May 1, 1987.)

40-12-12. Options to promoters, officers or employees. (a) Issuance of an option of stock of a domestic insurer to promoters, officers or employees shall be authorized only when it is satisfactorily demonstrated that the promoters, officers or employees have rendered a genuine service of value to the company for which they have not otherwise been fully compensated.

(b) The issuance shall be permitted if:

(1) The total number of shares subject to the option shall not exceed 10 percent of the number of authorized shares initially sold and issued for cash.

(2) The exercise price stated in the option to be issued by a domestic insurer is not less than the net price at which shares are sold to public investors at the time the option is granted, plus an increase of 10 percent for each year thereafter elapsing during the life of the option.

(3) The option shall be non-transferable except upon death of the optionee or by operation of law.

(4) The option terms shall not be exercisable more than five years after the date of issue.

(c) The intention to issue an option and the approximate extent shall be fully disclosed in the prospectus or offering circular.

(d) An option shall be a form of promotional expense and shall be justified by a showing of the nature of the service rendered or other consideration justifying the grant of the option. The aggregate of all organizational expenses and promotional expenses, including the value of the option as determined by the board of directors and subject to review by the commissioner, shall be subject to a permissible maximum of 12½ percent of the total amount actually paid for the issuer's capital stock. (Authorized by K.S.A. 40-103; implementing K.S.A. 40-205; effective Jan. 1, 1968; amended May 1, 1980; amended May 1, 1981; amended May 1, 1986; amended May 1, 1987.)

40-12-13. Officers, directors, and employee stock purchase plans. Stock option plans in a domestic insurer shall conform to the following specifications:

(a) Stock options shall be provided for by a fair and reasonable plan which has been submitted to and approved by the board of directors and stockholders after the company has been in operation for at least one full year.

(b) The granting of the stock option shall bear a reasonable incentive relationship to the continual employment of the optionee.

(c) The stock option shall be for a stated number of shares, to be paid for in cash.

(d) If the stock is widely traded, the options shall be for the full market value at the time the options are granted. If the stock is not widely traded, the options shall be for a price fixed by the company's board of directors and approved by the commissioner.

(e) The stock option shall fully set forth employment qualifications, conditions for complete exercise of the options, conditions under which cessation of employment shall terminate the option, and the effect of death, resignation, or other similar events.

(f) The stock option shall contain an anti-dilution or proration clause. The clause shall provide that the number of shares allocated to the plan and the number of shares carried by each individual option, and price per share, shall automatically be proportionately adjusted for each increase or decrease in the number of issued and outstanding shares of the corporation. This shall be accomplished without a corresponding increase or decrease in the corporation's paid-in capital.

(g) Only the optionee, or a court appointed guardian, shall exercise the option during the optionee's lifetime. For a specified time after death, only the heirs, administrator or executor shall exercise the option.

(h) The period of time in which an option may be exercised after death shall be no longer than five years.

(i) The total number of shares set aside at any one time for this purpose shall not be inequitably proportioned to the number of shares issued and outstanding. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effective Jan. 1, 1968; amended May 1, 1980; amended May 1, 1986; amended May 1, 1987.)

40-12-14. Purchasing of shares through options. A stock purchase plan or option in a domestic insurer shall provide that the optionee shall sign a stipulation when the option is exercised that the purchase of the shares shall be for investment and not for resale. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effective

Jan. 1, 1968; amended May 1, 1986; amended May 1, 1987.)

40-12-15. Pro rata exercising of options. A stock plan or option shall provide that the optionee shall exercise a pro rata portion of the options each year or the relevant portion shall automatically expire. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effective Jan. 1, 1968; amended May 1, 1986.)

40-12-16. Agents' production stock option plans. In order to be authorized, each agent's stock option plan in a domestic insurer shall:

(a) Be clear and unambiguous in its term and as simple as the subject matter permits;

(b) provide that the plan shall be submitted to and approved by the company's directors and stockholders before it becomes effective;

(c) provide that no securities shall be issued without a prior permit of the commissioner authorizing the issue. The company shall promptly and diligently endeavor to process the necessary authorization contemplated by the plan;

(d) provide that business written shall serve as a basis for earning options only after the business shall have been in force and effect for two policy years and premiums for the same period shall have been fully paid in cash. A policy that shall terminate by a death claim prior to expiration of the persistency period shall be regarded as having run the full two years;

(e) govern the earning of conditional rights to options and the grant of options by a conservative formula based on one of the following:

(1) Annual premiums written and paid on policies issued during a given calendar quarter;

(2) commissions earned per calendar quarter; or,

(3) another reliable criterion of production of business, per calendar quarter, having intensive value to the company;

(f) provide for notifying each participating agent within 30 days after the close of each calendar quarter of the number of shares to which conditional rights have been earned by virtue of production for the calendar quarter, according to the stated formula. Notification shall constitute evidence of the conditional rights to receive options for an appropriate number of shares after expiration of the persistency period and subject to all other conditions precedent. The notification form shall not be used without prior approval in writing by the commissioner;

(g) provide for the issuance of an option with reasonable promptness after expiration of the persistency period according to the formula chosen in subparagraph (e), and subject to fulfillment of all other conditions outlined in this section;

(h) specify that an option to be granted shall be exercisable for not longer than 180 days after issuance, after which they shall become null and void;

(i) specify that an option granted shall be nonassignable and nontransferable;

(j) limit the maximum number of shares optionable at any given time to a number equivalent to 10 percent of the company's then issued and outstanding or authorized shares;

(k) provide that options shall not be granted to any agent on the basis of personal or controlled business;

(l) provide in effect that agents appointed by the same company shall not transact insurance on each other or on each other's families for the purpose of avoiding the foregoing provision;

(m) provide that no agent shall be required to purchase any insurance personally, or that no agent's immediate family shall be required to participate;

(n) state that the price for issuance of the shares of stock shall be determined by the company's board of directors and approved by the commissioner;

(o) provide that rights to options for shares earned by an agent's production in accordance with the production formula shall abate pro rata at conclusion of the persistency period or prior to issuance of the actual options in any case where issuance of options would exceed the amount authorized by permit of the commissioner; and

(p) specify that after due notice to the persons concerned the commissioner may modify or terminate any or all of the following:

(1) The plan when continuation of the plan is inequitable;

(2) rights to options when issuance of options upon maturity is or shall be inequitable; and

(3) outstanding, issued but unexercised, options when issuance of shares is or shall be inequitable. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effective Jan. 1, 1968; amended May 1, 1980; amended May 1, 1981; amended May 1, 1986; amended May 1, 1987.)

40-12-17. Limitation of options. If the total number of shares of a domestic insurer are, at any one time, subject to outstanding unexercised option rights which exceed or will exceed 20 percent of the number of the then-issued and outstanding shares, it shall be presumed that an unfair, unjust and inequitable situation exists. The number of outstanding unexercised option rights shall include promotional options, employee incentive options, and agents production options. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effective Jan. 1, 1968; amended May 1, 1986; amended May 1, 1987.)

40-12-18. Options to attorneys-at-law, actuaries, and underwriters. An option in a domestic insurer to an attorney at law, or an actuary employed on a consulting basis, and to an underwriter under agents' production stock option plans shall be prohibited. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effective Jan. 1, 1968; amended May 1, 1986; amended May 1, 1987.)

40-12-19. Directors' resolution as to fairness of price; commissioner's approval. (a) Each application for authorization to issue options in a domestic insurer shall be supported by a certified copy of a resolution of the applicant's board of directors containing its findings, as follows:

(1) In the case of an applicant who demonstrates to the commissioner's reasonable satisfaction that:

(A) its shares have, through substantial trading in a free market, achieved a recognizable value in the market place;

(B) the market price reported is a bona fide market price;

(C) in the opinion of its board of directors, the market price represents the fair value of the shares; and

(D) the issuance at the proposed price will be equitable to the company, to its present and future stockholders, and to other optionees.

(2) In the case of an applicant which is either newly organized, or, if not newly organized, whose shares have not yet achieved a recognized value in the market place as described in paragraph (1) of this regulation, that:

(A) the value of the shares as stated represents, the fair value of the same; and

(B) that the option price sought to be authorized is an equitable price with respect to the company, its present and future stockholders, and the optionees.

(b) An application for authorization to issue options shall be approved by the commissioner if the price is equitable with respect to the company, its present and future stockholders, and other optionees, and the proposed plan complies with the other provisions of Kansas law and regulations. (Authorized by K.S.A. 40-103, 40-205; implementing K.S.A. 40-205; effective Jan. 1, 1968; amended May 1, 1980; amended May 1, 1981; amended May 1, 1986; amended May 1, 1987.)

Article 13.—INSIDER STOCK TRADING

40-13-1. Definition of certain terms. (a) "Insurer" means any domestic insurance company with an equity security subject to the terms of K.S.A. 40-264, 40-265, 40-266, 40-267, 40-268, 40-269, and not exempt by the provisions of K.S.A. 40-270.

(b) "Director" means those persons named as directors in the articles of incorporation for the first year, or those persons elected as directors by the stockholders.

(c) "Officer" means the president, vice-president, treasurer, secretary, controller, actuary or any other person who performs at the election or appointment by the board of directors of the corporation.

(d) Securities "held of record":

(1) Securities shall be deemed to be "held of record" by each person who is identified as the owner of the securities on a record of security holders maintained by or on behalf of the insurer, subject to the following:

(A) In each case where the records of security holders have not been maintained in accordance with accepted practice, each additional person who would be identified as an owner on such records if they had been maintained in accordance with accepted practice shall be included as a holder of record.

(B) Securities identified as held of record by a corporation, a partnership, a trust whether or not the trustees are named, or other organization shall be considered to be held by one person.

(C) Securities identified as held of record by one or more persons as trustees, executors, guardians, custodians or in other fiduciary capacities with respect to a single trust, estate or account shall be considered to be held of record by one person.

(D) Securities held by two or more persons as co-owners shall be considered to be held by one person.

(E) Each outstanding unregistered or bearer certificate shall be considered to be held of record by a separate person, except to the extent the insurer can establish that if the securities were registered they would be held of record under the provisions of this rule by a lesser number of persons.

(F) Securities registered in substantially similar names where the insurer has reason to believe, because of the address or other indications, that the names represent the same person, may be included as held of record by one person.

(2) Notwithstanding subsection (1) of this paragraph:

(A) Securities held with the knowledge of the insurer that they are subject to a voting trust, deposit agreement, or similar arrangement shall be of interest in the securities. The insurer may rely in good faith on information received in response to its request from a nonaffiliate of the certificates or evidence of interest.

(B) If the insurer knows or has reason to know that the method of holding securities of record is used primarily to circumvent the provisions of a statute or these regulations, the beneficial owners of the securities shall be deemed the record owners.

(e) "Class" means all securities of an insurer which are of similar character and the holders of which enjoy similar rights and privileges. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-264; through 40-271; effective Jan. 1, 1967; amended May 1, 1980; amended May 1, 1981; amended May 1, 1986; amended May 1, 1987.)

40-13-2. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-265; effective Jan. 1, 1967; amended May 1, 1986; revoked May 1, 1987.)

40-13-3. Reporting of securities. Information concerning the beneficial ownership of securities shall be given as of January 31, 1966, or in the case of persons who subsequently assume any of the relationships specified in K.S.A. 40-264, as of the date that the relationship was assumed. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-264; effective Jan. 1, 1967; amended May 1, 1986.)

40-13-4. (Authorized by K.S.A. 40-264 *et seq.*, 40-271; effective Jan. 1, 1967; revoked May 1, 1980.)

40-13-5. Ownership of more than 10 percent of an equity security. (a) In determining whether a person is the beneficial owner, directly or indirectly, of more than 10 percent of any class of any equity security for the purpose of K.S.A. 40-264, the class shall be deemed to consist of the total number of shares of the class outstanding, but shall not include any securities of the class held by or for the account of the insurer or a subsidiary of the insurer.

(b) The class of voting trust certificates or certificates of deposit shall consist of the number of shares of voting trust certificates or certificates of deposit issuable out of the total amount of outstanding shares of the class which may be deposited under the voting trust agreement or deposit agreement in question, whether or not all of the outstanding securities have been so deposited.

(c) A person acting in good faith may rely on the information contained in the latest annual statement filed with the commissioner concerning the number of shares outstanding in a class or, in the case of voting trust certificates or certificates of deposit, the number issuable.

(d) In determining whether a person is the beneficial owner, directly or indirectly, of more than 10 percent of any class of equity security for the purpose of K.S.A. 40-264, a person shall be deemed to be the beneficial owner of securities of the class in which the person has the right to acquire securities through the exercise of presently exercisable options, warrants or rights, or through the conversion of presently convertible securities.

(e) The securities subject to the options, warrants, rights or conversion privileges held by a person shall be deemed to be outstanding for the purpose of computing, the percentage of outstanding securities of the class owned by the person described in paragraphs (a), (b) and (c), but shall not be deemed outstanding for the purpose of computing the percentage of the class owned by any other person. This paragraph shall not be construed to relieve a person of any duty to comply with K.S.A. 40-264 with respect to equity securities consisting of options, warrants, rights or convertible securities which are otherwise subject, as a class, to K.S.A. 40-264. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-264; ef-

fective Jan. 1, 1967; amended Jan. 1, 1970; amended May 1, 1986; amended May 1, 1987.)

40-13-6. Disclaimer of beneficial ownership. Each person filing a statement may expressly declare that the filing of the statement shall not be construed as an admission that the person is, for the purpose of K.S.A. 40-264 and 40-265, the beneficial owner of any equity securities covered by the statement. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-264, 40-265; effective Jan. 1, 1967; amended May 1, 1986.)

40-13-7. Exemptions from K.S.A. 40-264 and 40-265. (a) During the period of 12 months following their appointment and qualification, securities held by the following persons shall be exempt from K.S.A. 40-264 and 40-265.

(1) An executor or administrator of the estate of the decedent;

(2) a guardian or conservator; and

(3) a receiver, trustee in bankruptcy, assignee for the benefit of creditors, conservator, liquidating agent, and other similar persons duly authorized by law to administer the estate or assets of other persons.

(b) After the 12 month period following their appointment or qualification, the foregoing persons shall be required to file reports with respect to the securities held by the estates which they administer under K.S.A. 40-264, and shall be liable for profits realized from trading in securities pursuant to K.S.A. 40-265 of the code when the estate being administered is a beneficial owner of more than 10 percent of any class of equity security of an insurer subject to the code.

(c) Securities reacquired by or for the account of an insurer and held by it or for its account shall be exempt from K.S.A. 40-264 and 40-265 during the time they are held by the insurer. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-264, 40-265; effective Jan. 1, 1967; amended Jan. 1, 1970; amended May 1, 1986; amended May 1, 1987.)

40-13-8. (Authorized by K.S.A. 40-271; implementing K.S.A. 40-264 *et seq.*; effective Jan. 1, 1967; amended May 1, 1980; revoked May 1, 1981.)

40-13-9. Certain transactions subject to K.S.A. 40-264 of the code. The acquisition or disposition of each transferable option, put, call, spread or straddle shall be a sufficient change in the beneficial ownership of the security to which the privilege relates to require the filing of a statement reflecting the acquisition or disposition of the privilege. This section shall not exempt a person from filing the statement required upon the exercise of an option, put, call, spread or straddle. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-264; effective Jan. 1, 1967; amended May 1, 1986.)

40-13-10. Ownership of securities held in trust. (a) Beneficial ownership of a security, for the purpose of K.S.A. 40-264, shall include:

(1) The ownership of securities as a trustee where either the trustee or members of the immediate family have a vested interest in the income or corpus of the trust;

(2) the ownership of a vested beneficial interest in a trust; and

(3) the ownership of securities as a settlor of a trust in which the settlor has the power to revoke the trust without obtaining the consent of all the beneficiaries.

(b) Beneficial ownership of a security, for the purpose of K.S.A. 40-264, shall not include:

(1) Beneficial ownership of securities solely as a settlor or beneficiary of a trust if less than 10 percent in market value of the securities having a readily ascertainable value held by the trust at the end of the preceding fiscal year of the trust consists of equity securities; and

(2) an obligation which would otherwise be imposed solely by reason of ownership as settlor or beneficiary of securities held in trust where the ownership, acquisition, or disposition of securities by the trust is made without prior approval by the settlor or beneficiary. An exemption under this subsection shall not be acquired or lost solely as a result of changes in the value of the trust assets during any fiscal year or during any time when there is no transaction by the trust in the securities otherwise subject to the reporting requirements of K.S.A. 40-264.

(c) In the event any class of any equity security of an insurer is held in a trust, the trust and the trustees shall file the reports specified in K.S.A. 40-264.

(d) One report shall be filed to report any holdings or any transaction in securities held by a trust, regardless of the number of officers, directors or 10 percent stockholders who are either trustees, settlors, or beneficiaries of a trust. The report shall disclose the names of each trustee, settlor, and

beneficiary who is an officer, director or 10 percent stockholder. A person having an interest only as a beneficiary of a trust shall not be required to file a report so long as the person shall rely in good faith upon an understanding that the trustee of the trust shall file whatever reports may be required of the beneficiary.

(e) As used in this section the "immediate family" of a trustee means:

(1) A son or daughter of the trustee, or a descendant of either;

(2) a stepson or stepdaughter of the trustee;

(3) the father or mother of the trustee, or an ancestor of either;

(4) a stepfather or stepmother of the trustee; and

(5) a spouse of the trustee.

(f) A legally adopted child shall qualify the determination of the "immediate family" relationship.

(g) In determining, for the purposes of K.S.A. 40-264, whether a person is the beneficial owner, directly or indirectly, of more than 10 percent of any class of any equity security, the interest of the person in the remainder of trust shall be excluded from the computation.

(h) A report shall not be required by any person whether or not otherwise subject to the requirement of filing reports under K.S.A. 40-264, with respect to the indirect interest in portfolio securities held by:

(1) A pension or retirement plan holding securities of an insurer whose employees generally are the beneficiaries of the plan,

(2) a business trust with over 25 beneficiaries.

(i) This section shall not impose any duties or liabilities with respect to reporting any transaction or holding prior to its effective date. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-264; effective Jan. 1, 1967; amended May 1, 1980; amended May 1, 1981; amended May 1, 1986.)

40-13-11. Exemption for small transactions. (a) An acquisition of a security or securities shall be exempt from K.S.A. 40-264 where:

(1) The person acquiring the security or securities does not dispose of them within six months therefore, except by a gift of securities of the same class; and

(2) the person acquiring the security or securities does not participate in acquisitions or in dispositions of securities of the same class having a total market value in excess of $3,000 for any six month period during which the acquisitions occur.

(b) Each acquisition or disposition of securities by gift, where the total amount of the gifts does not exceed $3,000 in market value for any six month period, shall be exempt from K.S.A. 40-264 and may be excluded from the computations prescribed in paragraph (a)(2).

(c) Each person exempted by section (a) or (b) of this regulation shall include in the first report filed after a transaction within the exemption, a statement showing the acquisitions and dispositions for each six month period and portion thereof, which has elapsed since the last filing. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-264; effective Jan. 1, 1967; amended May 1, 1980; amended May 1, 1981; amended May 1, 1986.)

40-13-12. Exemption from K.S.A. 40-265 of transactions which will not be reported under K.S.A. 40-264. Any transactions exempt from the requirements of K.S.A. 40-264 shall, be exempt from K.S.A. 40-265. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-264, 40-265; effective Jan. 1, 1967; amended May 1, 1986; amended May 1, 1987.)

40-13-13. Exemption from K.S.A. 40-265 of certain transactions effected in connection with a distribution. (a) Each purchase and sale, or sale and purchase, of a security which is effected in connection with the distribution of a substantial block of securities shall be exempt from the provisions of K.S.A. 40-265 if:

(1) The person effecting the transacting buys and sells securities in the ordinary course of business;

(2) the person is acting in good faith;

(3) the security involved in the transaction is:

(A) Acquired with the intent to distribute it for the insurer or other person on whose behalf it is being offered; or

(B) purchased in good faith by or for the account of the person initiating the transaction in order to stabilize the market price of securities of the type being offered, or to cover an over-allotment or other short position created by the offering, and

(4) other persons not within the purview of K.S.A. 40-265 participating in the offering shall be doing so on terms at least as favorable as the person initiating the transaction and all other persons

exempted from the provisions of K.S.A. 40-265. Bona fide payment for performing the functions of a distributing group shall not preclude an exemption otherwise available under this section.

(b) The exemption of a transaction pursuant to this section, with respect to the participation of one party, shall not render the transaction exempt to the extent of any other person unless that party also meets the conditions of this section. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-265; effective Jan. 1, 1967; amended May 1, 1986.)

40-13-14. Reserved.

40-13-15. Exemption from K.S.A. 40-265 of certain transactions in which securities are received by redeeming other securities. Each acquisition of an equity security (other than a convertible security or right to purchase a security) by a director or officer of the insurer issuing the security shall be exempt from the operation of K.S.A. 40-265, upon condition that:

(a) The equity security is acquired by way of redemption of another security of an insurer substantially all of those assets other than cash (or government bonds) consist of securities of the insurer issuing the equity security so acquired, and which:

(1) Represented substantially a stated or readily ascertainable amount of the equity security;

(2) had a value which was substantially determined by the value of such equity security; and

(3) conferred upon the holder the right to receive the equity security without the payment of a consideration other than the security redeemed.

(b) A security of the same class as the security redeemed was not acquired by the director or officer within six months prior to the redemption or shall be acquired within six months after the redemption;

(c) The insurer issuing the equity security acquired has recognized the applicability of paragraph (a) of this section by appropriate corporate action. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-265; effective Jan. 1, 1967; amended May 1, 1986.)

40-13-16. Exemption of long-term profits incident to sales within six months of the exercise of an option. (a) Subject to the limitations of subsection (b), each transaction involving the purchase and sale, or sale and purchase, of an equity security which is pursuant to the exercise of an option or similar right shall be exempt from the provisions of K.S.A. 40-265 if it is acquired:

(1) More than six months before its exercise; or

(2) pursuant to the terms of an employment contract entered into more than six months before its exercise if the contracts are approved by the commissioner of insurance.

(b) For transactions specified in paragraph (a), the profits inuring to the insurer shall not exceed the difference between the proceeds of sale and the lowest price of any security of the same class within six months before or after the date of sale. Nothing in this section shall enlarge the amount of profit which would inure to the insurer in the absence of this section.

(c) Transactions of the following character are exempt from the provisions of K.S.A. 40-265:

(1) The disposition of a security purchased in a transaction specified in section (a) of this regulation pursuant to a plan or agreement for merger or consolidation, or reclassification of the insurer's securities;

(2) a plan or agreement for the exchange of the insurer's securities for the securities of another person who has acquired the insurer's assets or who is in control of a person that has acquired the insurer's assets, as defined in section 368(c) of the internal revenue code of 1954;

(3) where the terms of the plan or agreement are binding upon all stockholders of the insurer except to the extent that dissenting stockholders may be entitled under statutory provision or provisions contained in the certificate of incorporation, to receive the appraised or fair value of their holdings.

(d) The exemptions provided by this regulation shall not apply to any transaction made unlawful by K.S.A. 40-266 or by any rules and regulations thereunder.

(e) The burden of establishing market price of a security for the purpose of this regulation shall rest upon the person claiming the exemption. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-265; effective Jan. 1, 1967; amended May 1, 1980; amended May 1, 1981; amended May 1, 1986.)

40-13-17. Exemption from K.S.A. 40-265 of certain acquisitions and dispositions of securities pursuant to merger or consolidations. (a) The following transactions shall be exempt from the provisions of K.S.A. 40-265:

(1) The acquisition of a security of an insurer, pursuant to a merger or consolidation, in exchange for a security of a company which, prior to the merger or consolidation, owned 85 percent or more of the equity securities of all other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

(2) the disposition of a security, pursuant to a merger or consolidation of an insurer which, prior to the merger or consolidation, owned 85 percent or more of the equity securities of the other companies involved in the merger or consolidation except, in the case of consolidation, the resulting company;

(3) the acquisition of a security of an insurer, pursuant to a merger or consolidation in exchange for a security of a company which, prior to the merger or consolidation, held over 85 percent of the combined assets of the companies undergoing merger or consolidation, computed according to their book values prior to the merger or consolidation as determined by their most recent available financial statements for a 12 month period prior to the merger or consolidation.

(4) the disposition of a security, pursuant to a merger or consolidation, of an insurer which, prior to the merger or consolidation, held over 85 percent of the combined assets of the companies undergoing merger or consolidation computed according to their book values prior to merger or consolidation, as determined by their most recent available financial statements for a 12 month period prior to the merger or consolidation.

(b) A merger within the meaning of this regulation shall include the sale or purchase of substantially all of the assets of one insurer by another in exchange for stock which is then distributed to the security holders of the insurer which sold its assets.

(c) The exemption provided by this regulation shall be unavailable to an officer, director, or stockholder who shall:

(1) Make any purchase, other than a purchase exempted by this regulation, of a security in any company involved in the merger or consolidation; and

(2) make any sale, other than a sale exempted by this regulation, of a security in any other company involved in the merger or consolidation. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-265; effective Jan. 1, 1967; amended Jan. 1, 1970; amended May 1, 1986.)

40-13-18 and 40-13-19. (Authorized by K.S.A. 40-264 *et seq.*, 40-271; effective Jan. 1, 1967; revoked Jan. 1, 1970.)

40-13-20. Certain securities transactions not violative of K.S.A. 40-266. (a) A person shall not be deemed to have violated the provisions of K.S.A. 40-266 if:

(1) the security transaction is in the process of execution by a broker of an order for an account in which the person has no direct or indirect interest; or

(2) a sale made by, or on behalf of, a dealer in connection with a distribution of a substantial block of securities meets the following conditions:

(A) The sale is represented by an over-allotment in which the dealer is participating as a member of an underwriting group, or the dealer or a person acting for the dealer intends to offset the sale with a security to be acquired by or on behalf of the dealer as a participant in an underwriting, selling, or soliciting-dealer group of which the dealer is a member at the time of the sale, whether or not the security to be acquired shall be subject to a prior offering to existing security-holders or some other class of persons; and

(B) other persons not within the purview of K.S.A. 40-266 shall be participating in the distribution of the block of securities on terms at least as favorable as those on which the dealer is participating and to an extent at least equal to the aggregate participation of each person exempted from the provisions of K.S.A. 40-266 by this section. The performance of the functions of a manager of a distributing group and the receipt of a bona fide payment for performing the functions shall not preclude an exemption which would otherwise be available under this subsection.

(3) The security shall be acquired by any person who is entitled as an incident to ownership of an issued security, and without the payment of consideration to receive another security "when issued" or "when distributed," if:

(A) The sale shall be made subject to the same conditions as those attached to the right of acquisition;

(B) the person shall exercise reasonable diligence to deliver the security to the purchaser promptly after the right of acquisition matures; and

(C) the person shall report the sale on the appropriate form for reporting transactions by persons subject to K.S.A. 40-264.

(b) This subsection shall not be construed as exempting transactions involving both a sale of a security "when issued," or "when distributed," and a sale of the security where the seller expects to receive the "when issued" or "when distributed" security, if the two transactions result in the sale of more units than the aggregate owned by the seller, and those to be received by him or her pursuant to his or her right of acquisition. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-266; effective Jan. 1, 1967; amended May 1, 1980; amended May 1, 1986.)

40-13-21 and 40-13-22. (Authorized by K.S.A. 40-264 *et seq.*, 40-271; effective Jan. 1, 1967; revoked May 1, 1980.)

40-13-23. Arbitrage transactions under K.S.A. 40-268. It shall be unlawful for any director or officer of an insurer to effect any foreign or domestic arbitrage transaction in any equity security of an insurer, unless the transaction shall be included in the statements required by K.S.A. 40-264, and the director or officer shall account to the insurer for the profits arising from the transaction as provided in K.S.A. 40-265. The provisions of K.S.A. 40-266 shall not apply to arbitrage transactions. The provisions of chapter 40, Kansas statutes annotated shall not apply to any bona fide foreign or domestic arbitrage transaction effected by any person other than a director or officer of the insurer. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-268; effective Jan. 1, 1967; amended May 1, 1980; amended May 1, 1986.)

40-13-24. Exemption from K.S.A. 40-265 of certain transactions; conversion of equity securities. (a) Deposit or withdrawal of equity securities under a voting trust or deposit agreement. Each acquisition or disposition of an equity security involved in the deposit of a security under, or the withdrawal of security from, a voting trust or deposit agreement, and the acquisition or disposition in connection therewith of the certificate representing the security, shall be exempt from the operation of K.S.A. 40-265 if all assets held under the voting trust or deposit agreement immediately after the deposit or immediately prior to the withdrawal consisted of equity securities of the same class as the security deposited or withdrawn. This section shall not apply if the following conditions exist:

(1) A purchase of an equity security of the class deposited and a sale of any certificate representing an equity security of the class; or

(2) a sale of an equity security of the class deposited and purchase of a certificate representing an equity security of the class, other than in a transaction involved in the deposit or withdrawal or in a transaction exempted by another provision of the regulations under K.S.A. 40-265, within a period of less than six months which includes the date of the deposit or withdrawal.

(b) Any acquisition or disposition of an equity security involved in the conversion of an equity security which, by its terms or pursuant to the terms of the insurer's charter or other governing instruments, shall be converted immediately or after a stated period of time into another equity security of the same insurer, shall be exempt from the operation of K.S.A. 40-265. This section shall not apply if the following conditions exist:

(1) A purchase of an equity security of the class convertible (including any acquisition of or change in a conversion privilege) and a sale of any equity security of the class issuable upon conversion, or

(2) a sale of an equity security of the class convertible and a purchase of any equity security issuable upon conversion, other than in a transaction involved in the conversion or in a transaction exempted by another provision of K.S.A. 40-265, within a period of less than six months which includes the date of conversion.

(c) An equity security shall not be acquired or disposed of upon conversion of an equity security if the terms of the equity security converted require the payment or entail the receipt, in connection with the conversion, of cash or other property, other than equity securities involved in the conversion, equal in value at the time of conversion to more than 15 percent of the value of the equity security issued upon conversion.

(d) An equity security shall be convertible if it is convertible at the option of the holder or of some other person or by operation of the terms of security or the governing instruments. (Authorized by K.S.A. 40-103, 40-271; implementing K.S.A. 40-265; effective Jan. 1, 1970; amended May 1, 1980; amended May 1, 1986.)

40-13-25. (Authorized by K.S.A. 40-264 *et seq.*, 40-271; effective Jan. 1, 1970; revoked May 1, 1980.)

40-13-26. Exemption from K.S.A. 40-265 of certain transactions involving the sale

of subscription rights. (a) Each sale of a subscription right to acquire a subject security of the same insurer shall be exempt from the provision of K.S.A. 40-265 if:

(1) The subscription right is acquired, directly or indirectly, from the insurer without the payment of consideration;

(2) the subscription right by its terms expires within 45 days after the issuance thereof;

(3) the subscription right by its terms is issued on a pro rata basis to all holders of the beneficiary security of the insurer; and

(4) a registration statement under the securities act of 1933 is in effect for each subject security, or the applicable terms of each exemption from registration have been met.

(b) When used within this section, the following terms shall have the meaning indicated:

(1) "Subscription right" means any warrant or certificate evidencing a right to subscribe to or otherwise acquire an equity security;

(2) "beneficiary security" means a security registered pursuant to section 12 of the securities exchange act, to the holders of which a subscription right is granted; and

(3) "subject security" means a security which is the subject of a subscription right.

(c) The sale of subscription rights, otherwise exempted by this section, shall not be exempted purchases within the six month period preceding or following the sale. (Authorized by K.S.A. 40-103, 40-281; implementing K.S.A. 40-265; effective Jan. 1, 1970; amended May 1, 1986.)

Article 14.—INSURANCE PREMIUM FINANCE COMPANIES

40-14-1. Insurance premium finance companies; changes in officers; management. (a) Each premium finance company authorized in Kansas shall report to the commissioner of insurance each change in officers and directors, as listed on page one of the application form, and file for each a biographical sketch, unless a biographical sketch has been previously filed upon admission to this state.

(b) Each premium finance company authorized in this state shall report the sale of controlling stock interests to the insurance department within 30 days after such sale is completed and the controlling interests are transferred. (Authorized by K.S.A. 40-103, 40-2608; implementing K.S.A. 40-2604; effective Jan. 1, 1969; amended May 1, 1986; amended April 16, 1990.)

40-14-2. (Authorized by K.S.A. 40-2604, 40-2608; effective Jan. 1, 1969; revoked May 1, 1979.)

40-14-3. Insurance premium finance companies; annual reports. (a) Each licensee shall file a report annually with the commissioner of insurance. The report shall contain information concerning the business and operations during the preceding calendar or fiscal year within the state.

(b) The report shall be filed on or before the first day of April. The time for filing may be extended by the commissioner of insurance for a period not in excess of 60 days.

(c) The report shall be subscribed and affirmed by the licensee under the penalty of perjury. The report shall be in the form prescribed by the commissioner of insurance who may make and publish annually an analysis and recapitulation of the reports. (Authorized by K.S.A. 40-103, 40-2608; implementing K.S.A. 40-2607; effective Jan. 1, 1969; amended May 1, 1986.)

40-14-4. Same; printing of forms. The printing of the items required by K.S.A. 40-2609, paragraph C, must be in at least 10 point, pica style type and print at least as bold as any other printing on the premium finance agreement. The style of type required by this regulation shall be used on all premium finance agreements delivered on and after January 1, 1991. (Authorized by K.S.A. 40-103, 40-2608; implementing K.S.A. 40-2609; effective Jan. 1, 1969; amended May 1, 1986; amended April 16, 1990.)

40-14-5. Same; duplicate to borrower. A duplicate of each premium finance agreement shall be delivered to the borrower before the due date of the first installment. (Authorized by K.S.A. 40-103, 40-2608; implementing K.S.A. 40-2609; effective Jan. 1, 1969; amended May 1, 1986.)

40-14-6. Same; notice of assignment; payments. Unless the borrower has notice of actual or intended assignment of a premium finance agreement, payment by the borrower to the last known holder of the agreement shall be binding upon all subsequent holders or assignees. (Authorized by K.S.A. 40-103, 40-2608; implementing K.S.A. 40-2609, 40-2611, 40-2612; effective Jan. 1, 1969; amended May 1, 1986.)

40-14-7. Same; service charges. (a) A

service charge on a premium finance agreement written at the inception of the applicable insurance policy may be computed from the effective date of the policy. A 30 day delay shall be allowed between the inception date of the insurance policy and the consummation date of the premium finance agreement for computing service charges.

(b) A service charge of less than $1.00 need not be refunded due to elapsed time frames between inception and consummation of the insurance policy and the consummation date of the premium finance agreement, or because of prepayment of the premium finance agreement. (Authorized by K.S.A. 40-103, 40-2608; implementing K.S.A. 40-2610; effective Jan. 1, 1969; amended May 1, 1979; amended May 1, 1986.)

40-14-8. (Authorized by K.S.A. 40-103, 40-2608; implementing K.S.A. 40-2609; effective Jan. 1, 1969; amended May 1, 1986; revoked May 1, 1987.)

40-14-9. Same; disclosure of annual percentage rate. (a) Each premium finance company shall include in its premium finance agreement a provision to disclose the annual percentage rate pursuant to Kansas administrative regulation 75-6-26.

(b) The total service charges included for a premium finance agreement and the total interest charged on the agreement shall be added together when computing the annual percentage rate of the disclosure. (Authorized by K.S.A. 40-103, 40-2608; implementing K.S.A. 40-2609, 16a-3-206; effective, E-69-20, Sept. 1, 1969; effective Jan. 1, 1970; amended May 1, 1979; amended May 1, 1986; amended May 1, 1987.)

40-14-10. Same; rates; filing. Each premium finance company shall file with the commissioner of insurance a complete listing of all scheduled interest rates and service charges which the company intends to use in Kansas. Such listing shall be revised and refiled as necessary to continuously reflect current rates and charges. (Authorized by K.S.A. 40-103 and 40-2608; implementing K.S.A. 40-2609; effective, T-40-9-25-92, Sept. 25, 1992; effective Feb. 8, 1993.)

Article 15.—VARIABLE ANNUITIES OR SEPARATE ACCOUNTS

40-15-1. Variable annuity or separate accounts; definition. (a) The term "contract on a variable basis" or "variable contract," when used in this regulation, shall mean each policy or contract which provides for variable insurance or annuity benefits according to the investment experience of a separate account or accounts maintained by the insurer as to a policy or contract, as provided for in K.S.A. 40-436 of the laws of this state.

(b) "Variable contract agent," when used in this regulation, shall mean an agent who shall sell or offer to sell any variable contract.

(c) "Securities examination," as used in paragraph 40-15-8 of this regulation, shall mean any one of the following examinations:

(1) Each state securities sales examination accepted by the securities and exchange commission;

(2) the national association of securities dealers, inc. examination for principals, or examination for qualification as a registered representative;

(3) the various securities examinations required by the New York stock exchange, the American stock exchange, Pacific stock exchange, or any other registered national securities exchange;

(4) the securities and exchange commission test given pursuant to section 15(b)(8) of the securities exchange act of 1934; or

(5) the examination recommended for the testing of variable contract agents by the national association of insurance commissioners, when adopted by the insurance department of any state or territory of the United States and approved for use by the department by the securities and exchange commission. (Authorized by K.S.A. 40-103, 40-436; implementing K.S.A. 40-436; effective Jan. 1, 1969; amended Jan. 1, 1970; amended, E-71-24, July 1, 1971; amended Jan. 1, 1972; amended May 1, 1986.)

40-15-2. Same; qualification of insurance companies. (a) Before any company shall deliver or issue for delivery variable contracts within this state the company shall submit to the commissioner of insurance a general description of the kinds of variable contracts it intends to issue.

(b) A copy of the statutes and regulations of the domicile state under which the company is authorized to issue variable contracts shall be submitted upon the commissioner's request. (Authorized by K.S.A. 40-103, 40-436; implementing K.S.A. 40-436; effective Jan. 1, 1969; amended May 1, 1981; amended May 1, 1986.)

40-15-3. Same; conditions. (a) A domestic company issuing variable contracts shall establish one or more separate accounts pursuant to K.S.A. 40-436.

(b) The investments and liabilities of a separate account shall be clearly identifiable and distinguishable from the other investments and liabilities of the corporation. An investment of a separate account shall not be pledged or transferred as collateral for a loan.

(c) The sale, exchange or other transfer of assets may not be made by a company between its separate accounts, or between any other investment account and one or more of its separate accounts unless:

(1) In case of a transfer into a separate account, the transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made; and

(2) the transfer, whether into or from a separate account, is made:

(i) by a transfer of cash; or

(ii) by a transfer of securities having a valuation which could be readily determined in the marketplace and the transfer of securities is approved by the commissioner of insurance. The commissioner may authorize other transfers among accounts if, in his opinion, the transfers would not be inequitable.

(d) The company shall maintain in each separate account assets with a value at least equal to the reserves and other contract liabilities with respect to the account, except as approved by the commissioner of insurance.

(e) An officer or director of the company or a member of the committee, board or body of a separate account shall not receive, directly or indirectly, any commission or any other compensation with respect to the purchase or sale of assets of the separate account. (Authorized by K.S.A. 40-103, 40-436; implementing K.S.A. 40-436; effective Jan. 1, 1969; amended May 1, 1986.)

40-15-4. Same; filing of contracts. The filing requirements applicable to variable contracts shall be the filing requirements for individual and group life insurance contract form filings under K.S.A. 40-216, 40-420, 40-421 and 40-434. (Authorized by K.S.A. 40-103, 40-436; implementing K.S.A. 40-436; effective Jan. 1, 1969; amended May 1, 1986; amended May 1, 1987.)

40-15-5. Same; variable benefits requirements. (a) The commissioner shall disapprove or withdraw approval of any contract form or certificate if:

(1) the contract or certificate contains provisions which are unjust, unfair, inequitable, ambiguous, misleading, likely to result in misrepresentation or contrary to law; or

(2) sales of the contracts are being solicited by any means of advertising, communication or dissemination of information which involves misleading or inadequate description of the provisions of the contract.

(b) Illustrations of benefits payable under any contract providing benefits payable in variable amounts shall not include projections of past investment experience into the future or attempted predictions of future investment experience. Use of hypothetical assumed rates of return to illustrate possible levels of annuity payments shall not be prohibited.

(c) An individual variable contract calling for the payment of periodic stipulated payments or premiums shall not be delivered or issued for delivery in this state unless it contains in substance one of the following provisions:

(1) A provision that there shall be a period of grace of 30 days or of one month, within which any stipulated payment or premium to the insurer falling due after the first day may be made, during which period of grace the contract shall continue in force. The contract may include a statement of the basis for determining the date for which the payment received during the period of grace shall be applied to produce the contract values;

(2) a provision that, at any time within three years from the date of default, in making periodic stipulated payments or premiums to the insurer during the life of the annuitant and unless the cash surrender value has been paid, the contract may be reinstated upon payment to the insurer of the overdue payments, and of all indebtedness to the insurer on the contract, including interest. The contract may include a statement of the basis for determining the date for which the amount to cover overdue payments and indebtedness shall be applied to produce the contract values; or

(3) a provision specifying the available options case of default in a periodic stipulated payment. The options may include an option to surrender the contract for a cash value as determined by the contract, and shall include an option to receive a paid-up annuity if the contract is not surrendered for cash. The amount of the paid-up annuity shall

be determined by applying the value of the contract at the annuity commencement date in accordance with the terms of the contract.

(d) Each individual variable annuity contract delivered or issued for delivery in this state shall stipulate the expense, mortality, and investment increment factors used in computing the dollar amount of variable benefits or other contractual payments or values, and may guarantee that expense and/or mortality results shall not adversely affect the dollar amounts.

"Expense," as used in this paragraph, may exclude some or all taxes, as stipulated in the contract.

In computing the dollar amount of variable benefits or other contractual payments or values under an individual variable annuity contract:

(1) The annual net investment increment assumption shall not exceed five percent, except with the approval of the commissioner;

(2) To the extent that the level of benefits may be affected by mortality results, the mortality factor shall be determined from the annuity mortality table for 1949, ultimate, or any modification of that table not having a higher mortality rate at any age, or, if approved by the commissioner, from another table.

(e) The reserve liability for variable annuities shall be established pursuant to the requirements of the standard valuation law in accordance with actuarial procedures that recognize the variable nature of the benefits provided. (Authorized by K.S.A. 40-103, 40-436; implementing K.S.A. 40-436; effective Jan. 1, 1969; amended May 1, 1986.)

40-15-6. Same; required reports. (a) Each company issuing an individual variable contract providing benefits in variable amounts shall mail to the contractholder at least once a year following the first contract year, at the last address known to the company, a statement or statements reporting the investments held in the separate account. In the case of contracts under which payments have not begun, the statement shall report as of a date not more than four months previous to the date of mailing.

(b) In both instances, the report shall contain:

(1) The number of accumulation units credited to the contracts and the dollar value of a unit; or

(2) the value of the contractholder's account.

(c) The company shall submit annually to the commissioner of insurance a statement of the business of its separate account or accounts in such form as may be prescribed by the national association of insurance commissioners. (Authorized by K.S.A. 40-103, 40-436; implementing K.S.A. 40-436; effective Jan. 1, 1969; amended May 1, 1986; amended May 1, 1987.)

40-15-7. Same; agents; qualification. (a) Unless licensed as a variable contract agent, an agent shall not be eligible to sell or offer for sale a variable contract.

(b) An agent who participates only in the sale or offering for sale of variable contracts that are not registered under the federal securities act of 1933 shall not be required to be licensed as a variable contract agent. (Authorized by K.S.A. 40-103, 40-436; implementing K.S.A. 40-241; effective Jan. 1, 1969; amended Jan. 1, 1970; amended May 1, 1986.)

40-15-8. Variable annuity or separate accounts; agents; procedure for obtaining licenses. (a) Each agent desiring to sell, pursuant to K.S.A. 40-436, individual or group contracts on behalf of a life insurance company regularly admitted to do business in this state, shall apply for a license to sell the contracts on a form designated by the commissioner of insurance.

(b) An application for a license shall be accepted only from an individual who:

(1) At the time of application, is licensed to write life insurance on behalf of the company certifying the application;

(2) submits evidence of passing a security examination defined in K.A.R. 40-15-1; or

(3) submits evidence of being currently registered with the federal securities and exchange commission as a broker-dealer, or of being currently associated with a broker-dealer and having met qualification requirements with respect to the broker-dealer association.

(c) A broker-dealer or a person associated with a broker-dealer who is engaged directly or indirectly in the sale of securities, or who supervises, recruits or trains securities sales persons, shall have passed a "securities examination" or shall have been continuously engaged in the securities business since July 1, 1963.

(d) Except as otherwise provided by this regulation, each applicant shall be governed by the provisions of K.A.R. 40-7-1 through K.A.R. 40-7-19. (Authorized by K.S.A. 40-103, 40-436; implementing K.S.A. 40-241; effective Jan. 1, 1969; amended, E-71-24, July 1, 1971; amended Jan. 1,

1972; amended May 1, 1979; amended May 1, 1986.)

40-15-9. (Authorized by K.S.A. 40-103, 40-436; effective Jan. 1, 1969; amended Jan. 1, 1970; amended, E-71-24, July 1, 1971; amended Jan. 1, 1972; amended Jan. 1, 1973; revoked May 1, 1979.)

40-15-10. (Authorized by K.S.A. 40-103, 40-436; effective Jan. 1, 1969; amended, E-71-24, July 1, 1971; amended Jan. 1, 1972; revoked May 1, 1979.)

40-15-11. (Authorized by K.S.A. 40-103, 40-436; effective Jan. 1, 1969; amended Jan. 1, 1970; amended, E-71-24, July 1, 1971; amended Jan. 1, 1972; revoked May 1, 1979.)

40-15-12. (Authorized by K.S.A. 40-103, 40-436; effective Jan. 1, 1969; revoked May 1, 1979.)

Article 15a.—VARIABLE LIFE INSURANCE

40-15a-1. Variable life insurance; definitions; qualifications; requirements; reports. The national association of insurance commissioners' variable life insurance model regulation, December 1982 edition, is hereby adopted by reference, subject to the following exceptions and additions: (a) Article I, Article IV Section 3a(5), and Article XII are not adopted.

(b) Section 2, Article II is hereby amended by adding the words "or broker" immediately following the words "insurance agent."

(c) Section 8, Article II is hereby completed by inserting "K.S.A. 40-436" in the space provided.

(d) Section 16, Article II is hereby completed by inserting "K.S.A. 40-436" in the space provided.

(e) Section 19, Article II is hereby completed by inserting "K.S.A. 40-437" in the space provided.

(f) Section 4, Article III is hereby completed by inserting "K.A.R. 1984 Supp. 40-9-118 *et seq.*" in the space provided.

(g) Section 2(f), Article IV is hereby completed by inserting "K.S.A. 40-428" in the space provided.

(h) Section 3c(1), Article IV is hereby amended to read as follows: "All overdue premiums, with interest at a rate not exceeding 6% per annum compounded annually, and any indebtedness in effect at the end of the grace period following the date of default, with interest as provided in K.S.A. 1984 Supp. 40-420a through 40-420d, inclusive; or"

(i) Section 3c(2), Article IV is hereby completed by inserting "6%" in the space provided.

(j) Section 4a, Article IV is hereby completed by inserting "2" in the space immediately preceding the words "full years."

(k) Section 5a, Article IV is hereby completed by inserting "2" in the space provided.

(l) Section 1, Article VI is hereby completed by inserting "K.S.A. 40-436 and 40-437" in the space provided.

(m) Section 1c, Article VI is hereby amended to read as follows: "Each person with access to the cash, securities, or other assets of the separate account shall be under bond as provided by K.S.A. 40-207." (Authorized by K.S.A. 40-103, 40-436; implementing K.S.A. 40-436, 40-437; effective May 1, 1975; amended May 1, 1984; amended May 1, 1986.)

40-15a-2 to 40-15a-8. (Authorized by K.S.A. 40-436; effective May 1, 1975; revoked May 1, 1984.)

40-15a-9. (Authorized by K.S.A. 40-436; effective May 1, 1975; amended May 1, 1979; revoked May 1, 1984.)

Article 15b.—UNIVERSAL LIFE INSURANCE

40-15b-1. Universal life insurance; definitions; qualifications; requirements; reports. The national association of insurance commissioners' universal life insurance model regulation, 1996 edition, is hereby adopted by reference, subject to the following exceptions and additions:

(a) Section 1, Section 2, and Subsections (F) and (I) of Section 3 are not adopted.

(b) Section 4 is hereby amended by striking "Section 25 of the NAIC Model Variable Life Insurance Regulation" and substituting "Kansas Administrative Regulation 40-15a-1."

(c) Section 4 is further amended by adding the following paragraph: "Nothing in this regulation shall be construed as superseding any statutory provision or any Kansas administrative regulation except to the extent this regulation or a provision of it is inconsistent with or contrary to another regulation."

(d) Section 7, Subsection F, second paragraph is not adopted and shall be replaced with the following: "As required by K.S.A. 40-420, a flexible premium policy shall provide for a grace period of at least 30 days after it lapses. Unless otherwise defined in the policy in a way that is more favorable to the insured, lapse shall occur on the date the net cash surrender value first equals zero."

(e) Section 10, Subsection A is hereby amended by deleting the last sentence of the first paragraph.

(f) Section 10, Subsection B, paragraph 3 is hereby amended by the addition of the following paragraph: "Each foreign insurer shall be subject to the same information requirements as domestic insurers unless the required descriptions are filed on a timely basis with the insurer's state of domicile."

(g) Section 10, Subsection B, paragraph 1 is not adopted.

(h) Section 10, Subsection C is not adopted. (Authorized by K.S.A. 40-103, 40-436; implementing K.S.A. 40-436, 40-437; effective May 1, 1985; amended May 1, 1986; amended Oct. 23, 1998.)